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ABSTRACT

The proceedings of a 1984 conference on improving rehabilitation services to minority populations with handicaps contains 24 papers grouped into six sections. Two papers in the first section focus on changes which have occurred in the rehabilitation systems and current challenges. The second section, which focuses on research, contains five papers that explore innovative approaches, social support in disease and disability, frequency and distribution of disabilities among Blacks, and service delivery issues at referral and closure. Section III contains four papers which discuss medical and sociocultural aspects of disability such as Blacks and physical disability and the role of disabled Hispanics. The impact of media, technology, and assistive technologies on the nonwhite disabled population is considered in the three papers in Section IV. The fifth section discusses preparation of professionals and career development for the disabled and contains five papers which look at college based training, the training of speech-language pathologists, access for nonwhite disabled students to community colleges, nontraditional career approaches, and a New York work experience program. The final section contains five papers which pertain to the development and utilization of community-based resources, support systems (the Black church, local resources), and political means, and advocacy mechanisms to promote rehabilitation of the nonwhite disabled. (CB)

Proceedings of the National Conference of the Howard University Model to Improve Rehabilitation Services to Minority Populations with Handicapping Conditions

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Perspectives, Problems, and Strategies in the Rehabilitation of the Nonwhite Disabled

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Bureau of Educational Research, School of Education
Howard University

Proceedings of the 1984 National Conference
of the Howard University Model
to Improve Rehabilitation Services to Minority
Populations with Handicapping Conditions

Equal to the Challenge

Perspectives, Problems, and Strategies in the Rehabilitation of the Nonwhite Disabled

Edited by

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Robert W. Nicholls

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This publication is an outcome of the National Conference/Training Workshop. Each of the presenters was invited to submit his/her presentation for possible inclusion in the published proceedings. Those papers which were submitted were carefully reviewed by the editors. Final selections were based on relevance to the conference purpose and objectives as stated above. Papers selected for inclusion were edited and, in several instances, expanded.

The papers contained in these proceedings are divided into six major categories. In Section One (Past and Present Implications for Rehabilitation) Anderson and Fenderson examine a number of broad issues and concerns by focusing on changes which have occurred in the rehabilitation systems as well as current challenges. Section Two (Research Focus) contains five chapters which explore rehabilitation from several vantage points with regard to the needs and functioning of the nonwhite disabled. Atkin's paper deals with the challenge of developing innovative approaches to research and the status of blacks in the rehabilitation system. Belgrave examines the impact of social support in disease severity in chronically ill black patients. Miller's paper reports on black patient's perceptions of adjustment to disability and social support. The Walker, Belgrave, Roberts, Palmer, and Newsome study focuses on a comparison of the prevalence of selected disabilities among several ethnic groups. Ross and Biggi examine several critical vocational rehabilitation service delivery issues at referral and closure in New York State.

The Medical and Sociocultural Aspects of Disability are addressed in Section Three. Thornhill and Torres provide several observations on blacks and physical disabilities. Wilson gives an in-depth view of sociocultural variables and their impact on disability. Garza and Suazo explore issues and concerns pertinent to the needs of disabled Hispanics. The former addresses socio-economic and cultural problems affecting the delivery of rehabilitation services to Hispanic blind and visually impaired individuals, whereas the latter focuses on the emerging role of the disabled Hispanic.

The impact of Media and Technology are discussed in Section Four. Fiorito and Doherty compare the portrayal of blacks and the disabled in the media. Fowler discusses the importance of the media in shaping perceptions about the disabled; Nicholls provides an extensive account of the availability and benefits of current technology and its potential for facilitating the independence of the disabled.

The Section titled "Preparation of Professionals and Career Development for the Disabled" provides the reader with an array of information and training strategies pertinent to career development. Both Sanders and Payne discuss university level professional training programs in their respective papers. Each of the chapters by Vernon, Kapur, and Wolinsky, et al. deal with career development, training, and work experience programs for the disabled. The concluding section "Resources, Support Systems, and Advocacy" consists of a cross section of papers, all of which have relevance to the development and utilization of community-based support systems which result in access to the rehabilitation system by the nonwhite disabled. Wells and Banner address the role of the black church. King and Galiber, in each of their papers, discuss the utilization of resources. In the last two chapters, Galloway and Young focus on various aspects of advocacy.

It is felt that each of the papers included in these proceedings contains information which may facilitate a) more effective delivery of rehabilitation services to the nonwhite disabled population, b) increased access to the system by nonwhites, and c) an increased understanding of the needs and capabilities of the focal group. The contribution of each of the contributors is greatly appreciated.

At this very critical time in the U. S. history, it is hoped that these proceedings will serve as a gateway to increased effective communication and understanding.

Sylvia Walker, Ed.D.
L. Deno Reed, Sc.D.

PREFACE

Throughout this century, America has been attempting to devise effective programs of service for disabled individuals. However, the most significant strides toward the delivery of comprehensive services have been made since 1950. During the last decade notable achievements have been attained in the provision of equal opportunity for all disabled individuals. Part of the progress has been made because national attention has been drawn to the nearly 35 million persons in our society who have special needs due to some handicapping condition. Much of the gain has been a result of expanded research in the areas of human development and rehabilitation. A great degree of the success is due to comprehensive approaches to health, social, and educational programs and issues at the national level. Major generic programs such as social security, the poverty program, economic development, comprehensive health insurance, and programs designed to improve the quality of life for all, have helped to identify and reduce the incidence and impact of handicap on a person and society. Special federal and state legislation and subsequent service program development which have been carried out from the early 1960's to the present day (notably the Comprehensive Mental Health-Mental Retardation laws, the Veterans Administration laws, the Economic Opportunity Act, the Rehabilitation Act, the Civil Rights Act, the Maternal and Child Health laws, the Facilities Construction laws, PL 94-142 [The Education of All Handicapped Children Act], and the Developmental Disabilities Act), have created a fabric of activity and set the stage for effective action. In spite of these advances, there is still substantial progress to be made, especially in the area of the provision of services to the nonwhite disabled population.

While it is true that disabled persons who are members of racial and ethnic minorities suffer the same indignities as other disabled individuals, there are special and unique problems that these individuals face because of the lack of awareness of their cultural differences. In addition, prejudice and racial discrimination continue to exclude a great number of nonwhite persons from full participation in all aspects of society.

In the early 1980's the National Institute of Handicapped Research (NIHR), U.S. Department of Education, substantiated the need for research and demonstration projects which respond to the needs of minority populations with handicapping conditions by making this concern one of its priority areas. Since 1983, the Howard University Model to Improve Rehabilitation Services to Minority Populations with Handicapping Conditions (funded by NIHR) carried out a number of research, service, training, and dissemination activities designed to increase the participation of the nonwhite disabled in the rehabilitation system.

A major outcome of the Howard University Project during 1984, was the implementation of a National Conference/Training Workshop. The 1984 National Conference was designed to facilitate the attainment of maximum potential by individuals with handicapping conditions. An objective of this conference was to bring together experts and representatives from all over the United States to focus upon issues, problems, and effective approaches relative to the needs of nonwhite disabled persons. This training conference enabled participants to: a) acquire new information with regard to theories and practices relative to the needs of the nonwhite disabled, b) engage in dialogue with diverse professional and disability groups, and c) participate in the development of innovative approaches to the solution of problems which impact upon a substantial segment of the disabled population in the United States. Each of the achievement objectives were attained during the two and a half day conference which took place at Howard University. Well over two hundred persons from all regions of the United States attended this meeting. A total of 42 stimulating presentations were made.

CONTENTS

Contents iii
Preface v
Acknowledgements vii
Dedication vii

SECTION I: PAST AND PRESENT IMPLICATIONS FOR REHABILITATION

1. **Rehabilitation for the Nonwhite Disabled: A Formidable Challenge**
   Elizabeth H. Anderson 1
2. **Redefining the Unacceptable**
   Douglas A. Fenderson 7

SECTION II: RESEARCH FOCUS

3. **Innovative Approaches and Research in Addressing the Needs of Nonwhite Disabled Persons**
   Bobbie J. Atkins 11
4. **The Role of Social Support in Disease Severity in Chronically Ill Black Patients**
   Faye Z. Belgrave and Deborah Moorman-Lewis 17
5. **Patients' Perceptions of Their Adjustment to Disability and Social Support in a Community Based Teaching Hospital**
   Sheila Miller 22
6. **Frequency and Distribution of Disabilities Among Blacks: Preliminary Findings**
   Sylvia Walker, Elizabeth Akpati, Veronica Roberts, Ruth Palmer, and Moses Newsome 27
7. **Critical Vocational Rehabilitation Service Delivery Issues at Referral (02) and Closure (08,26,28,30) in Serving Select Disabled Persons**
   M. Gerlene Ross and Ian M. Biggi 39

SECTION III: MEDICAL AND SOCIOCULTURAL ASPECTS OF DISABILITY

8. **Some Observations on Blacks and Physical Disability**
   Herbert L. Thornhill and Luz Torres 51
9. **Sociocultural Aspects of Disability and Rehabilitation**
   Milton E. Wilson 54
10. **Socio-Economic and Cultural Problems Affecting the Delivery of Rehabilitation Services to Hispanic Blind and Visually Disabled Individuals—Some Observations**
    Rolando Garza 67
11. **The Emerging Role of the Disabled Hispanics**
    Antonio Suazo 70

SECTION IV: MEDIA AND TECHNOLOGY

12. **Overcoming**
    Eunice Fiorito and Jim Doherty 73

13. **Images and Identity—In Marketing Adults with Disabilities in the Media**
Jesse W. Fowler 75

14. **New Assistive Technologies and the Nonwhite Disabled**
Robert W. Nicholls 80

SECTION V: PREPARATION OF PROFESSIONALS AND CAREER DEVELOPMENT FOR THE DISABLED

15. **A College-Based Rehabilitation Training Program for Working with the Nonwhite Disabled**
Charles D. Sanders 91

16. **A Model for Training Speech-Language Pathologists to Meet the Unique Needs of Minority Individuals**
Kay T. Payne 94

17. **Providing Access for Nonwhite Disabled Students to Community College Programs**
Sally T. Vernon 100

18. **Non-Traditional Career Approaches for Disabled Nonwhite Persons**
Sushila Kapur 104

19. **Work Experience Program for Disabled Students in the CUNY System: Implications for the Nonwhite Disabled**
Gloria F. Wolinsky, Rosalind R. Zuger, and Ann Marie Tully 111

SECTION VI: RESOURCES, SUPPORT SYSTEMS, AND ADVOCACY

20. **The Role of the Black Church in Advocating for the Disabled Community**
Mary Wells and Alma M. Banner 117

21. **Rehabilitation Information: The Local Resource Puzzle**
John W. King 121

22. **Utilizing an Information and Referral Agency in a Changing Society**
Yetta W. Galiber 126

23. **Using Traditional and Confrontational Politics to Influence Established Trends**
Don Abasi Galloway 130

24. **Observations of a Neophyte Lawyer "Four Observations—Three Proposed Solutions"**
Pamela J. Young 133

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We are grateful to those individuals who have worked very hard in the preparation of this publication. Special thanks are given to Ms. Leslie Anderson, Ms. Thelma Anderson, Ms. Donna Taft, and Ms. April Massey for editorial assistance. We are especially appreciative of the support which we have received from the School of Education at Howard University, the National Institute of Handicapped Research and Rehabilitation Service Administration (of the U.S. Department of Education), our National Advisory Committee, Local Task Force, and the eight cooperating state rehabilitation agencies.

Finally, the cooperation and collaboration rendered by administrators, staff, students, and faculty of various institutions and organizations facilitated the accomplishment of the project's goal, providing a stimulating and informative conference in an atmosphere of fellowship and the subsequent publication and dissemination of the conference proceedings.

This publication is dedicated
to the memory of
Mae Frances Johnson DeClue
of Atlanta, Georgia

SECTION I

Past and Present Implications for Rehabilitation

1 • Rehabilitation for the Nonwhite Disabled: A Formidable Challenge

ELIZABETH H. ANDERSON
National Rehabilitation Association

Abstract

This article states that blacks are overrepresented among the handicapped in America. It addresses the effects of federal cutbacks in social security and their impact on handicapped minorities. It compares some of the negative attitudes toward the handicapped in this country with those in Russia. The article also presents a systematic approach for maintaining federal and state funding for the nonwhite community during this period of fiscal restraint. It calls for intense advocacy by those who work with, support, and represent the minority handicapped in America in an effort to abate the fiscal cutbacks in government.

Based upon prevalence, incidence, and severity, black Americans are clearly in the forefront of disabled persons in America. Causation is varied and complex: birth defects, disease, trauma, war, substance abuse, mental illness, neurological and circulatory conditions.

The arcane program of peremptory disallowance of social security disability benefits without a hearing has created havoc, destruction, and the ultimate ... death, among many disabled persons. As advocates, our role must be to ensure the reinstatement of disabled persons so cruelly, wantonly, and senselessly assailed.

Let's look back to April 1982. In Indiana, Baby Doe was born with Down's Syndrome and digestive tract defects. Her natural parents rejected her. Although there were loving, accepting adoptive parents waiting for her in their warm homes, a judge, acting upon the plea of the natural parents, ruled that it was permissible, legally, to allow Baby Doe to starve to death.

By contrast, in Indiana, a rock group was performing and as part of their act, one of the performers bit off the head of a bat. The performer was arrested for cruelty to animals.

Since the first Baby Doe, there have been several cases with the same outcome. Where was the hue and cry for the rights of the born?

In the absence of such advocacy, the Surgeon-General of the United States, Dr. C. Everett Koop, played a major role in attempting to deal with the problem. He stated, "Each newborn infant, perfect or deformed, is a

human being with unique preciousness because he or she was created in the image of God." Rules promulgated by the U.S. Department of Health and Human Services (HHS) are designed to protect these infants. The Department is being sued by the American Hospital Association. An appeal on a negative decision by the United States District Court invalidating the HHS rules is in litigation.

Earlier this year, 1984, the Governor of Colorado implied that the elderly were using too many resources and should oblige the rest of society by giving up their lives. You can make your own inferences.

Last year, I was in the USSR to attend a rehabilitation seminar. In Moscow, a city of six million, I was struck by the absence of blind people, the absence of accessibility, the absence of those with birth defects, the absence of a person using a cane or crutch, the absence of the elderly. The same was true in Leningrad, a city of four to five million people. I was not given information about these absences, although I was in the USSR for two weeks. I got the clear impression that the USSR is a society where you produce or you are in trouble. Consider, there is no accessibility: not in buildings, the streets, airports, airplanes, or other public conveyances.

In 1977, the National Urban League and the National Association of Nonwhite Rehabilitation Workers, in cooperation with the White House Conference on Handicapped Individuals, developed a national program designed to examine rehabilitation in nonwhite communities. The program was funded by a federal grant. It is significant that seven years later we must continue to address these concerns.

Within the largest and most successful rehabilitation program in the world, the federal-state program in the United States of America, we see attempts each year to reduce funding and appropriations required to provide rehabilitation services for the disabled. If it were not for the National Rehabilitation Association, its members and friends, program and staff cuts already in progress would have been much more severe. I call your attention to the attached tables showing the administration's fiscal year 1985 budget as compared to the House and Senate recommendations. These figures reflect the efforts on the part of the Congress to appropriate a larger sum of money to the disabled community than that budgeted by the administration (See Appendix).

In order to continue this program, *we must be funded.* That is the bottom line. Your advocacy, your letters and phone calls to your Senators and Congressmen are essential to the continuation of this program. One of the battle cries of the new right is "cut social programs."

Keep in mind that most disabled persons who receive rehabilitation services do become wage earners and taxpayers. For example, in South Carolina, the number one federal-state program in the country and also the number one chapter in the National Rehabilitation Association, there were 8,000 successfully rehabilitated clients in 1982. These 8,000 successes increased their annual rate of earnings from $17.2 million to $55.2 million, a net increase of 66%. Rehabilitation costs are usually a one time expenditure for each client. Among this successful group of 8,000, 50% had mental disabilities. Other disabilities were: digestive tract disorders; hearing impairments; heart and circulatory conditions; allergy and endocrine disorders; visual impairments; epilepsy and other neurological disorders; respiratory diseases; absence of limbs; cancer; speech impairments; blood disorders; and other conditions.

With our active participation to assure continued funding for federal-state programs at minimal levels, we can meet the fiscal demands for rehabilitation needs in the nonwhite community as follows:

- Staff training, to ensure job access to rehabilitation positions at both graduate and undergraduate levels, must be pursued. Effective recruitment methods and programs must be developed within the nonwhite community.
- Outreach programs for disabled persons in nonwhite communities must be established at every point of contact e.g., schools, churches, doctors, hospitals and clinics, unions, worker's compensation, welfare, social security disability, and community organizations. Effective referrals to rehabilitation agencies must be made with adequate follow-up.
- Facilities and facility development must be initiated in nonwhite communities.
- Advocacy for the enforcement of the

Rehabilitation Act of 1973 and its amendments must be more persistent, tenacious, creative, innovative, and effective. Information and information systems as well as stimulation must be provided and utilized to prevent discrimination against disabled persons and to provide public acceptance for these laws. Every available means of communication should be utilized including the media.

- Disabled nonwhite persons must be included at every level in organizations of disabled persons as well as local, state, and federal advisory councils and instrumentalities.
- Immediate steps must be taken to include the nonwhite community in grants programs throughout the rehabilitation community in order to encourage research and innovation.
- Projects with industry must be a *sine qua non* to ensure job opportunities for persons who are disabled in nonwhite communities.
- Accessibility in schools at every level to facilitate mainstreaming must continue.
- Accessibility to vote and voter education are essential for every eligible disabled voter.
- National Rehabilitation Month, September, must be proclaimed as a national priority.

In closing, here is an illustration of "What Went Wrong?" It is a story about four people: Everybody, Somebody, Anybody, and Nobody.

There was an important job to be done and Everybody was sure that Somebody would do it. Somebody got angry because it was Everybody's job. Anybody could have done it, but Nobody did it. Everybody thought that Somebody would do it. But Nobody asked Anybody. It ended up that the job wasn't done, and everybody blamed Everybody when actually Nobody asked Anybody.

In the book of Ecclesiastes, it is said that there is a time for all things. LET US BEGIN!!!

Reference

Duncan, J. (1984). *Washington update*, L-84-15. Alexandria, VA: National Rehabilitation Association.

Appendix

Table I

FISCAL YEAR 1985 APPROPRIATIONS
FOR PROGRAMS AUTHORIZED UNDER THE
REHABILITATION ACT OF 1973, AS AMENDED
($ in millions)

	Administration's Budget	Senate Recommendation	House Recommendation	House & Senate Conference Recommendation
Basic State Grant	$1,003.9	$1,117.5	$1,092.8	$1,100.0
Evaluation (Sec. 14)	.5	2.0	2.0	2.0
Training	5.0	24.0	20.0	22.0
NIHR	30.0	40.0	38.0	39.0
Independent Living (B)	21.0	22.0(B)	21.0(B)	22.0(B)*
(Parts A, C)	--	5.0(A)**	1.0(C)***	5.0(A)**
Service Projects:				
• Client Assistance	-0-	6.3	5.1	6.3
• Special Projects for Severely Disabled****	14.6	13.6	14.6	14.6
• Helen Keller Center (removed from the Act)	3.7	4.2	4.2	4.2
• PWI	11.2	14.4	13.0	14.4
• Indian Tribes	.7	.7	.7	.7
• Special Recreation	-0-	2.1	2.0	2.1
• Technical Assistance	--	.2	--	--
• Migrant Workers****	1.0	.9	.9	.9
National Council on the Handicapped	.3	.7	.5	.7

*Independent Living Centers
**Comprehensive State ILR Services
***Independent living services for older blind
****Special Projects include special demonstration projects, migratory workers, and various other rehabilitation projects for which specific appropriations were not made.
(Duncan, 1984)

Table II

EDUCATION FOR THE HANDICAPPED
($ in millions)

	President's Budget	Senate Recommendation	House Recommendation	House & Senate Conference Recommendation
State Assistance Programs				
State Grant Program	$1,068.8	$1,135.1	$1,125.0	$1,135.1
Preschool Incentives	26.3	28.0	29.3	29.3
Total	$1,095.1	$1,163.1	$1,154.3	$1,164.4
Discretionary Programs				
Deaf-Blind Centers	12.0	15.0	15.0	15.0
Severely Handicapped Projects	4.0	4.3	4.0	4.3
Early Childhood	21.1	22.5	21.1	22.5
Regional, Adult, Voc. & Postsecondary	5.0	5.3	5.0	5.3
Media Services and Captioned Films	14.0	16.5	14.0	16.5
Regional Resource Centers	4.5	6.0	6.5	6.0
Innovation & Development	12.0	16.0	15.0	16.0
Recruitment	1.0	1.0	1.0	1.0
Personnel Development*	37.6	61.0	55.5	61.0
Special Studies	2.0	3.2	3.0	3.1
Secondary Education & Transitional Services	6.0	6.3	6.0	6.3
Total	$119.2	$157.1	$146.1	$157.0

* Includes funds for new Parent Training and Information Program (Duncan, 1984)

Table III

FISCAL YEAR 1985 APPROPRIATIONS FOR SPECIAL INSTITUTIONS
($ in millions)

	President's Budget	Senate Recommendation	House Recommendation	House & Senate Conference Recommendation
Gallaudet College	$46.8	$56.7	$58.7	$58.7
College programs	[38.6]	[37.8]	[39.8]	[39.8]
Model Secondary School for the Deaf	[4.9]	[12.2]	[12.2]	[12.2]
Elementary School	[3.2]	[6.6]	[6.6]	[6.6]
National Technical Institute for the Deaf	31.4*	31.4	31.4	31.4
Total	$124.9	$144.7	$148.7	$148.7
P.L. 89-313 State Operated Schools	$146.5	$153.8	$146.5	$150.1

*Of this amount, $1.4 million is requested for construction.

(Bracketed figures refer to amounts previously appropriated or proposed.)

Table IV

FISCAL YEAR 1985 APPROPRIATIONS FOR DEVELOPMENTAL DISABILITIES PROGRAM
($ in millions)

	President's Budget	Senate Recommendation	House Recommendation	House & Senate Conference Recommendation
State Grants	$45.4	$50.2	-0-	$50.2
Protection & Advocacy	8.4	13.7	-0-	13.7
Special Projects	2.6	2.7	-0-	2.7
University Affiliated Facilities	7.8	9.0	-0-	9.0
Total	$64.2	$75.6	-0-	$75.6

(Duncan, 1984)

2 • Redefining the Unacceptable

DOUGLAS A. FENDERSON
National Institute of Handicapped Research

Abstract

This article presents a general overview of the emerging role of rehabilitation and related services and how they have evolved to reflect conventional approaches. Legislation likewise has been enacted to address fragmented services and unacceptable barriers to rehabilitation. The formation of the National Institute of Handicapped Research (NIHR), which was the result of the Rehabilitation Act of 1973, and its funding options designed to support grants to improve services to special populations, are highlighted. Finally, reference is made to the Presidential Order 12320 which addresses priority for the funding of such grants.

The history of rehabilitation is a continuing redefinition of the unacceptable. Early in this century, the waste of human productivity caused by accidents in mining, railroad building, lumbering, and other heavy and dangerous industries became unacceptable. The rehabilitation solution was simply vocational retraining. Later, during and after World War I, added emphasis was given to physical restoration and improved artificial limbs. However, virtually all those with paraplegia died within a few weeks or months.

Epidemics and high-prevalence diseases such as polio and tuberculosis likewise presented unacceptable outcomes for those with disabling effects. Such conditions were a major stimulus in the development of the field of physical medicine and rehabilitation. In fact, the two physicians who wrote the first medical specialty examinations in this field had close involvement with these illnesses. Dr. Frank Krusen of the Mayo Clinic had recovered from tuberculosis and Dr. Miland Knapp, an orthopaedic surgeon, was concerned with the poor functional outcomes of persons whose limbs and joints were immobilized by splints and braces following disabling attacks of polio.

Then came World War II. Conventional wisdom said that sick people belong in bed and prolonged bed rest following surgery and obstetrical delivery were essential to recovery. A young medical officer, Dr. Howard Rusk, found the conventional medical wisdom to be unacceptable. Within limits of physical tolerance, patients on his wards, especially those with acute pneumonia, were kept physically active. The body was made for use. Forced inactivity, except when absolutely essential, is unhealthy. Rusk developed an approach he called "rehabilitative medicine." After World War II, the two approaches merged and became "Physical Medicine and Rehabilitation."

About this time, perhaps the most influential woman in government service, Mary Switzer, came on the scene. She found the fragmented and partial approaches to be unacceptable. She found the generally low level of professional training to be unacceptable. She found the tendency to stereotype the handicapped to be unacceptable. Many of the rehabilitation programs in the U.S. and abroad are a tribute to her farsighted leadership.

Since 1968, more than ten federal acts or amendments recognized that the de facto limitations on the civil rights of disabled persons were likewise unacceptable (DeJong and Lifchez, 1983). These include the Architectural Barriers Act of 1968 (P. L. 90-480); Accessible Mass Transit Act of 1970 (P. L. 91-453); Accessible Highway Facilities, 1973 (P. L. 93-87); the Section 504 Anti-discrimination Provisions of the 1973 Rehabilitation Act (P. L. 93-112); Protection and Advocacy

Systems for Developmentally Disabled Persons Act of 1975 (P. L. 94-103); The Education for All Handicapped Children Act of 1975 (P. L. 94-142); The Independent Living Priority of the Rehabilitation Amendments of 1978 (P. L. 95-602); and the removal of some work disincentives under the Social Security Amendments of 1980 (P. L. 96-265).

In 1978, Congress passed another piece of far-ranging legislation regarding the unacceptable state of knowledge in rehabilitation. This was Title II of the Rehabilitation Act of 1978 which established as a separate federal agency the National Institute of Handicapped Research (NIHR).

This morning, I will describe briefly the important authorities under this act, its current activities as they pertain to this conference; pertinent priorities, represented in its soon to be released long-range plan; and some observations on how the results of meetings such as this can influence priorities for rehabilitation research.

NIHR was established to emphasize the application of the methods of materials of science and technology to the challenges of disability and loss of normal function. It removed age barriers from such research. It was to include all ages, from birth to old age. It encompassed the full range of participants—disabled persons, parents and advocates, educators, physicians, therapists, behavioral scientists, engineers, and technologists, among others.

We were to develop a five-year plan every three years as a guide to all disability research, not just that supported by NIHR. The Director was to convene on a quarterly basis an Interagency Committee on Handicapped Research through which representatives of some twenty-nine federal agencies with identifiable interest in this field could coordinate their efforts and avoid unnecessary duplication of effort. We were to develop a national plan to communicate the results of research and technological development to all appropriate audiences throughout the country. We were to experiment with the use of telecommunications technology in closing communications gaps in rehabilitation information. Finally, we were required to keep in touch with other rehabilitation research programs throughout the world. Since 1978, impressive accomplishments have been achieved in each of these areas. I would invite specific inquiry regarding any of them, but I will move on quickly to current work in NIHR pertinent to your interests.

CURRENT WORK PERTINENT TO THIS CONFERENCE

This meeting is part of an NIHR-funded grant directed at the important priority of improving delivery of rehabilitation services to special populations. This initiative was in response to the Presidential Order 12320. This grant was the result, in part, of an invitational conference organized by our staff person, Ms. Rheable Edwards, to inform historically black colleges and universities of opportunities in rehabilitation research.

NIHR supports other grants to improve services to special populations. About 18 months ago, we convened a state-of-the-art conference on rehabilitation research needs regarding the Hispanic population in the United States. The first grant resulting from this effort was initiated last summer with Pan American University in Texas. We also support a research and training center (RTC) in geriatrics rehabilitation at Rancho Los Amigos in California which includes an emphasis on older disabled Hispanic persons who often do not use available rehabilitative services because of cultural barriers.

Two small RTC's addressing the needs of native Americans are supported through Northern Arizona State University and the University of Arizona. This work has led to an interest by the Indian Health Service to include rehabilitation assessment as part of their hospital program.

The University of Hawaii has also entered into an agreement with NIHR to study the rehabilitation needs of the native residents of the U.S. trust territories of Micronesia.

New NIHR funding options include the individual research fellowship program which seeks to expand the pool of leadership in rehabilitation research; the Innovative Grants Program to stimulate new ideas and opportunities in rehabilitation research and service programs; and the Field Initiated Research Grant Program which provides up to three years of support for well-designed research projects.

In keeping with the Presidential Order 12320 and the authority of the Director for final selection of projects from those eligible

for support, it is the intention of the Director to give priority to applications from historically black colleges and universities. Those interested may want to contact Ms. Edwards of our staff. Although these programs are published without specific priorities, NIHR has particular interest in early intervention in families with disabled children; early intervention in work-related disability; transition of disabled persons from school to work; economics of disability and rehabilitation; technology and disability; and independent living.

If the history of advances in rehabilitation of disabled persons is a continuing "Redefinition of the Unacceptable," let us plan now to take bold new steps in removing the unnecessary and unacceptable barriers to full participation in community life of disabled persons. Your project here at Howard is pointing the way.

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3 • Innovative Approaches and Research in Addressing the Needs of Nonwhite Disabled Persons

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Abstract

This article examines counseling approaches and research needs regarding service delivery to nonwhite persons with disabilities. Counselors must adjust their attitudes, responses, and goals regarding minority and nonwhite disabled clients based on their individual uniqueness. As concluded in Kolk's study (1977) of counselors' physiological responses to disabled and minority clients, additional research is needed in this area. Rehabilitation personnel must become aware of the deficiency-oriented research on minorities. Finally, some specific recommendations are outlined with regards to the rehabilitation of nonwhite females and the examination of assessment instruments.

We often attempt to explain behavior that we do not understand and many times do not accept. Such has been the case with societal problems and issues such as rape, college protests, suicide, disability, and homosexuality. This is also the case with racial minorities, a societal issue that affects every strand of American life. Yet, despite a few isolated cases, massive unified efforts to clarify and eliminate problems focused on race/ racism appear to be declining and in some areas almost nonexistent.

Since the early 1970's in rehabilitation, there has also been a trend toward less attention focused directly on the complexity of issues concerning research and delivery of rehabilitation services to minorities. Even though there appears to be a more recent resurgence of interest and writing related to counseling and minorities, a systematic and comprehensive approach to research and innovative strategies regarding disabled minorities continues to be elusive. Although worthwhile projects related to disabled minorities have been accomplished, much more needs to be accomplished. Therefore, the purpose of this paper is to explore some of the critical issues related to counseling approaches and research needs regarding service provision to nonwhites who are disabled.

APPROACHES AND RESEARCH

Each racial minority person enters the rehabilitation process/program with his/her own beliefs, attitudes, values, and goals.

Although some generalities may be postulated, individuals will not always behave according to these generalities. Thus, the information shared is to provide basic references which must be transmitted into useful specific knowledge for effective service delivery. There is no cookbook for providing services to minorities. "Helping relationships do not allow a rigid structure" (Henderson, 1979, p. 492). Yet, there are at least three major responsibilities for anyone who conducts research and counsels minorities. First, the "counselor should try to promote optimal personal and intellectual growth of the . . . client" (Henderson, 1979). Second, the counselor and researcher need to create a physically and psychologically safe environment for interaction to occur. Third, the rehabilitationist needs to be aware of cultural differences existing for minority clients.

In addition to these responsibilities, three assumptions warrant careful consideration for all researchers and counselors of minorities:

(a) Racism is operative in our society,
(b) Minorities are not treated equally to their majority peers, and
(c) We are all a part of the problem and the solution.

Typical emotions aroused by these assumptions include anger, fear, guilt, defensiveness, interest, disinterest, empathy, and commitment (verbal and action). Nevertheless, minorities are or will be a part of your case loads, and if viable solutions to some of the larger problems associated with race are not resolved, we are all losers.

The emotional and cognitive acceptance of racism requires increased awareness of the negative ramifications of a racist environment. No one can deny that fundamental injustices have been committed against persons in America for the irrelevant reason of race. Yet, the past needs to be behind us. The tragedy can only continue if we do not benefit from past failures. Viable alternatives can and must be found, but solutions will not develop out of a void.

By virtue of its philosophy and specialization in serving the disabled, rehabilitation is an excellent program to help disabled nonwhites transform potential into self-fulfilling roles (Atkins, 1980).

The goals of rehabilitation counseling reflect an awareness of individual uniqueness and that all persons have a human right to set their own priorities. To categorize all disabled minorities into one group reflects isolation and segregation which impedes the rehabilitation process. Thus, counselors, researchers, and administrators must examine their views of nonwhites who are disabled.

For example, the interesting idea of phantom counselor and client was introduced by Schumacher (1973). Usually the counselor and client have had a type of interaction before they meet physically. Records, previous agency contacts, referral information, etc., produce this phantom. This concept has a number of implications for both client and counselor and can often shape the relationship before it has an objective time to develop. The counselor and counselee can bring positive or negative attitudes to their first encounter. When majority counselors are dealing with minority disabled persons, negative attitudes often overshadow the positive. Educators and supervisors can caution students and staff about this type of contact, plus provide suggestions which can benefit both counselor and client.

Issues that tend to arise during counseling with the disabled minority client often include language, counseling goals, and client specific problems. The use by counselors of slang phrases and in-group terms that are not common to their communication style is fraught with danger. It is better that counselors ask questions when they do not understand and that they not allow communication differences to deter them from the client's concerns.

The success of the nonwhite disabled client is a function of the overall rehabilitation counseling process and not just the counseling experiences. Goals should be selected with client involvement to insure cooperation and the desired success.

Atkins (1980) and Schumacher (1973) believed that counseling disabled minorities involves the same ingredients as with the disabled majority but the client's condition, the agency, and the counselor impose special considerations for working with minority individuals.

In an article by Kolk (1977), it was pointed out that little attention has been paid to the physiological responses counselors experience when working with various disabled and minority clients. Investigations in this area have tended to point out discrepancies

between self-reported comfort and physiological comfort. Kolk's study was undertaken to try and answer such questions as: Will counselors experience high stress in relation to various disabled and minority clients? Will counselors' self-reported comfort with clients be consistent with measured physiological stress? Will minority (Black, Puerto Rican) counselors, because of their similarity with clients who have been stigmatized and labeled as different, experience stress to a lesser degree than white counselors with disabled and minority clients? Will females and males differ in their physiological responses to various clients?

Suggested counselor-client interactions were presented to graduate student counselors in training with the result that physiological arousal in the form of stress was found to occur in relation to five disabled and one minority client. It was learned that stress toward each client category occurred far beyond those found in the general interview situation. Kolk felt that his research supported the notion that the counselors' physiology does change as various clients are encountered.

It should be noted that stress was found within minority counseling students even though they verbalized relative comfort. It was not learned whether this discrepancy was due to a social desirability factor or lack of awareness by the students. Several factors may account for high stress on the part of minority students toward minority clients. First, added pressure may be felt by the student counselor because she/he and the client are members of a minority group. Second, responses may not be to the client per se, but to the context in which the client is found. A third factor for consideration is that minority counselors may identify themselves or feel the client identified them with the majority system, and consequently, the minority counselor is not free of stress in relating to a minority client.

The need for clarification and understanding in reference to black counselor stress with black clients is noted. Because so many (Atkins & Wright, 1980; Dean, Parker & Williams, 1977; Ford & Ford, 1978; McFadden, 1976) have advocated the use of minority counselors with minority clients, knowledge concerning stress may be very helpful. If it could be learned what factors produce stress for black counselors in working with black clients, strategies could be implemented to produce reductions in stress if it is felt to be a hindrance to service delivery and personal comfort for the client and/or counselor.

The conclusion from Kolk's study should not be made that all counseling students or counselors experience stress toward all disabled and minority clients. It could be concluded that additional studies are needed to determine individual differences in physiological responses to clients, that research in "real" settings would be valuable, and that differences and/or similarities between students and practicing rehabilitation counselors could facilitate our knowledge. Also, physiological response awareness to clients could be included as a component of inservice education for practitioners and within rehabilitation counselor education courses.

Rehabilitation educators, counselors, administrators, etc., need to be aware of the negative attitudes that may be fostered by research findings. Rehabilitation personnel must strive to interpret and utilize research results within a positive context. So much of the research done to *help* minority persons has only lead to more stereotyping and lack of access to mainstream America. Rehabilitation and other helping professions must always be on guard against improper use of research findings.

Smith (1977) pointed out that blacks have become the most researched minority group. Still, a great amount of this research *has not* led to a better understanding of how to counsel blacks, provide adequate rehabilitation services, and reduce stereotypes. "In an effort to sensitize others to the situations of members of a particular racial group, we sometimes ignore individual differences—defeating in part the very goals we set out to accomplish" (Smith, 1977, p. 390). Smith cautioned us that some investigators are not necessarily motivated by "good" intentions. Rehabilitation personnel must be aware of this as they review the literature on what has been written about nonwhite disabled clients.

Very often counseling research on minorities has been deficiency-oriented with studies usually stressing negative aspects. Often black clients are described as hostile, angry, or alienated both with themselves and the counselor. It is felt that this stereotypic presentation of blacks paves the way for stereotypic treatment. Smith said that "the recognition of cultural differences in the coun-

seling of blacks is one thing, but the stereotyping of these differences is quite another" (p. 391). Stereotyping has led to a portrait of a black client as a "deficient white client."

Numerous aspects of the literature on minorities are currently being questioned. Some researches have started to pose questions about the pervasive idea of negative self concepts of black individuals. Another area receiving attention in the form of questions is the myth of the non-verbal minority client. There is a difference between recognizing that a person refuses to talk for some reason and labeling him/her non-verbal. There is a difference between recognizing that people vary in their language style and trying to group them together according to their socioeconomic status and race.

It is encouraging to find that the counseling literature is reflecting concern with issues involving the minority female. Rehabilitation counseling has a tremendous task ahead in this area.

Counselors need to understand the frame of reference and establish trust with the disabled nonwhite female. "Those techniques used in traditional counseling settings that accentuate the importance of the individual can be useful" (Copeland, 1977, p. 400). An approach that places emphasis on strengths is desirable for counseling nonwhite females. This approach is not new to the rehabilitation educator or counselor. Throughout the literature, emphasis is placed on abilities not disabilities.

Much more emphasis needs to be given to the underrepresentation of black females in those careers that are nontraditional and in higher education. For the minority disabled woman, at least three factors must be confronted—race, sex, and disability. Such factors as the nature of the disability, aspirations, expectancies and social consequence are felt to be important to educational and career outcomes for the minority disabled female. Needed are strategies which can facilitate the entrance of black females into higher education and/or nontraditional careers. What is learned about the black nondisabled female can be utilized to better service those who are disabled.

Standardized tests are usually an important part of the assessment of clients within rehabilitation. The controversy over why minorities tend to show low performance on these tests has been explored by many (Anastasi, 1976; Vontress, 1971).

The concern is that nonwhite disabled persons' abilities are assessed, not just their inabilities. Rehabilitation counselors need to be aware of the limitations and strengths of the instruments they select. Adequate test-taking orientation and preliminary practice can benefit nonwhite disabled clients. Harmon, Sharma, and Trotter (1976) pointed out that the use of vocational inventories for clients from various cultural and experiential backgrounds has received little research attention. Yet, the use of these inventories within rehabilitation with nonwhites is often routine. The counselor must exercise caution in administering to nonwhites instruments designed for and standardized on the dominant white culture.

A case can be made for both the continuation and the discontinuation of the use of standardized tests with blacks within rehabilitation. Since it is felt, however, that this type of assessment will continue to be utilized within rehabilitation, a few suggestions seem appropriate:

1. Know as much about the client, the instrument, and the examiner as possible before scheduling testing.
2. The reading level of the client should be determined before selection of a test.
3. Use individual vs. group tests whenever possible.
4. Discuss the why and how of the test with the black client.
5. Seek the active participation of the examinee. Ask about their previous testing experiences, etc.

SPECIFIC RECOMMENDATIONS

The aforementioned approaches and research represent only limited concerns regarding nonwhite disabled persons. Similarly, the following specific recommendations are not exhaustive. Yet, it is felt that these recommendations can assist rehabilitation personnel as they work with nonwhite clients.

1. Competent rehabilitation personnel must be educated in cross-cultural counseling and research. Education needs to reflect an assertive, positive, and objective approach to learning.
2. A national policy and implementation plan, research and evaluation pro-

gram is essential. This program must be long-term and continuing.

3. All rehabilitation personnel must develop a sincere commitment to help advance the rights of disabled nonwhites.
4. Outstanding and exemplary rehabilitation programs and practices serving disabled minorities need to be researched and shared.
5. The most valuable resource available for assisting nonwhites in rehabilitation is the minority individual him/herself. Meaningful dialogue must be developed with potential and current consumers to obtain their views of their needs and their suggestions for improved delivery systems.
6. Teamwork is essential in developing strategies and methods for service provision to minority clients. Teamwork can assure the pooling of resources for the "good" of the consumer.
7. Self-help groups provide an excellent resource for use with minority clients. These groups provide, among other things, a sense of belonging and shared concerns, a method for self-expression, a way to assist others, and a way to learn from the experience of others.
8. The system of "networking" has a viable role in providing services to nonwhites. The linkage of the client to the needed system may be one of the most valuable services a rehabilitation worker may provide.
9. Realistic appraisal and use of such groups as the church, family, volunteer organizations, and political organizations have much to offer when assisting nonwhites.
10. Meaningful professional training programs can be another vehicle for increasing the participation of minorities in rehabilitation.
11. Public rehabilitation legislation should be used to ensure that resources are more directly provided to cross-cultural clients.
12. Self-advocacy, assertiveness training, and political astuteness need to be taught consistently to minority consumers.
13. The mass media must be educated and employed to advance the positive aspects of disabled minority experiences and culture.
14. Some of the basic questions that must be asked of minority persons which will begin to serve as a knowledge base for future planning include:
    a. What reasons do minorities give for not seeking rehabilitation services?
    b. What are the experiences (positive and/or negative) of nonwhites who do seek rehabilitation services?
    c. What do minority persons view as barriers to the availability, accessibility, acceptability, and adequacy of rehabilitation services?
15. Cross-culturally skilled rehabilitation personnel (CCSRP) must be able to generate appropriate and cross-culturally realistic options with their minority clients.
16. Knowledge and understanding of human rights, of cultural and rehabilitation politics, and of legal issues are required of CCSRP.
17. Assertiveness in casefinding of minority consumers is required. CCSRP must be willing to enter nonwhite communities in order to ensure adequate casefinding.
18. Individual differences among minority consumers must be assessed and respected.
19. Sincere and consistent recruitment programs must be developed and implemented to ensure that appropriate numbers of nonwhites are not only employed but retained and promoted in rehabilitation practice and education.
20. CCSRP must support and participate in research which explores minority issues from a constructive stance.
21. A national institute for research on minorities would facilitate rehabilitation investigations regarding disabled nonwhites.

Summary

Numerous service delivery questions continue to exist regarding disabled nonwhites. Rehabilitation research is an excellent vehicle for generating answers. Basic and applied research is warranted:

a. Who are minority disabled consumers?
b. How do minorities view disability?
c. What is the state-of-the-art regarding research related to nonwhites?
d. What rehabilitation practices impact on success for minority disabled consumers?
e. How can rehabilitation best recruit and retain nonwhite professionals

A primary role of the National Institute of Handicapped Research (NIHR) is to prompt quality services to persons who are disabled (PWD). In keeping with the national emphasis on employment of PWD, research is needed to identify, clarify, and recommend needed implementation strategies to better ensure successful rehabilitation of minorities.

NIHR has placed priority on "a need to promote the widespread adoption of new, tested, and validated practices and exemplary programs resulting from rehabilitation research and training that will improve and generally enhance the service delivery system for disabled individuals" (p. 4). The needs are identical for nonwhite disabled persons.

Rehabilitation personnel are concerned about the rights of all people and must use resources so that human dignity is assured for all oppressed persons. Therefore, it is felt that a reactivitation of concern, interest, and research has excellent potential for improved service delivery to nonwhite disabled citizens.

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4 • The Role of Social Support in Disease Severity in Chronically Ill Black Patients

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Abstract

Social support has a direct positive effect on health status and serves as a buffer for the effects of psychosocial and physical stress on the mental and physical health of the individual. The purpose of this study was to investigate the relationship between social support and disease severity in chronically ill black patients with sickle cell disease and diabetes. It was hypothesized that social support would be significantly related to disease severity in black patients with sickle cell disease and diabetes such that high availability of social support would be associated with less disease severity. The subjects sampled included 45 adult patients with sickle cell disease and 69 adult patients with diabetes. All patients attended Howard University Hospital outpatient clinics. The variables examined were the availability of social support and disease severity as measured by patient interviews and a symptom check list. Study results indicated that social support was significantly associated with disease severity in black patients with sickle cell disease and diabetes. However, a divergent pattern of relationships between social support and severity variables were found for the two groups. Clinical applications for the utility of the social support variable in treating patients with chronic illnesses are discussed.

The role of social support on mental and physical health status has been investigated in a number of studies. Social support has been found to have a direct positive effect on health status and to serve as a buffer of the effects of psychosocial and physical stress on the mental and physical health of the individual (Broadhead et al., 1983). The purpose of this study was to investigate the relationship between social support and disease severity in chronically ill black patients with sickle cell disease and diabetes.

Social support provides the information that tells a person that he or she is loved, valued, and part of a network of communication and mutual obligation (Cobb, 1976). This support may be emotional, cognitive, or instrumental (Caplan, 1979; Cobb, 1976). It is likely to be a combination of these. Emotional support provides love, reassurance, and a source of strength and hope. Cognitive support provides a source of information. Information processing may become impaired, particularly during periods of physical and emotional stress. Social support not only helps to reduce the anxiety that interferes with cognitive functioning but helps to provide alternative information. Instrumental support may be in the form of material aid and concrete assistance. Someone who is part of an emotional network is also likely to be cared for and helped materially.

For the person with a chronic illness, social support is especially important. A chronic illness may be defined as an altered state of health that cannot be cured by a simple surgical procedure or a short course of medical therapy (Miller, 1983). There are three general features of a chronic illness: a) the symptoms interfere with many normal activities and routines, b) the medical regimen is limited in its effectiveness, and c) treatment, although intended to relieve the symptoms and long range effects of disease, contributes substantially to the disruptions of usual patterns of living (Reif, 1975). Episodes of illness are often unpredictable and recurrent. The individual must cope with the per-

sonal meaning of having a chronic illness as well as living with the daily demands of health related care. Each crisis, physical or psychological, causes additional stress for individuals with chronic illnesses. Social support is very important.

Social support is especially an important variable to consider with black persons with chronic illnesses. Family, friends, church, and community play an important role in adjustment to mental and physical stress. Pearson (1984) advocates an ecological approach to treating black patients using family, friends, church, and community as resources to aid in treating the patient.

The study of social support and its relationship to disease severity in this population is important for two reasons. Very little research has been done using a sample of black patients with diabetes and none has been done using a sample of patients with sickle cell disease. Disease severity as a health status variable is of particular importance since it is likely to have a direct effect on adjustment to and coping with the illness.

The following hypothesis was tested. Social support will be significantly related to disease severity in black patients with sickle cell disease and diabetes such that high availability of social support will be associated with less disease severity.

METHOD

Study Samples

The sickle cell sample consisted of 45 patients attending the Howard University Center for Sickle Cell Disease. The mean age of these patients was 28. The sample consisted of 28 females and 17 males. Sickle cell disease is a genetic disorder of the red blood cells (Scott & Kessler, 1977). Upon deoxygenation, the defect causes the cells to assume a crescent shape. The aggregation of sickle cells which temporarily block small blood vessels causes pain. When severe enough, the pain is referred to as a painful crisis. Painful crises occur throughout the life of the patient in an unpredictable fashion. There may be other complications of the disease including infection and organ failure. This disease affects primarily those of African descent in this country and occurs in about one out of every 500 black Americans.

The diabetic sample consisted of 69 patients attending the diabetic out-patient clinic at Howard University Hospital. With the exception of two patients, all had maturity (adult) onset of diabetes. The mean age of these patients was 57. There were 37 females and 23 males. Diabetes is a disease caused by the body's failure to make use of certain foods in the proper way. (American Diabetic Association Fact Sheet, 1983). Diabetes develops because the body does not produce enough insulin or the body cannot make use of the insulin that is produced. The body is not able to use food properly and high levels of glucose accumulate in the blood and urine. Serious complications including blindness and kidney failure may follow. Diabetes occurs in about one child in 1,000 under age 10 and in about one adult in 50 over age 50 (Whitehouse, 1979). Diabetes strikes women and nonwhites more often than other Americans (American Diabetic Association Fact Sheet, 1983).

The two study samples were different in many respects. Sickle cell disease is a genetic disorder present at birth. While there is a genetic factor in the development of diabetes, the disease does not occur until a later age. Patients with sickle cell disease experience recurrent painful crises. Although there may be medical complications of diabetes, extreme pain does not occur to the degree that it does in patients with sickle cell disease.

Both diseases are chronic with recurring illness symptoms. Both are incurable. Regular medical management is necessary in order to minimize symptoms and complications. Frequently, psychological and social support may be needed to assist the patient in coping with the illness.

Demographically, the two study samples were different. Sickle cell patients were younger, better educated, and had slightly higher household incomes. The majority of the patients with sickle cell disease had high school diplomas, whereas the majority of the patients with diabetes did not.

INSTRUMENTS

Social Support

The social support scale was developed by Wilcox (1982) and is used to determine the frequency of supportive and helpful behaviors performed by others. The scale

measures the availability of emotional, cognitive, and instrumental support. Respondents are asked to indicate how available each type of help is by circling frequently available, sometimes available, or rarely available. Examples of scale items include someone who will listen to you carefully and talk over problems with you and someone who will lend you their car for a few hours. The reliability of this scale is acceptable and the validity is being established.

Measures of Disease Severity

The measures of disease severity were both perceptual and behavioral. Patients were asked about the severity of their illness and about medical treatment for their illness.

Perception of Severity of Disease—This scale was devised for use in this study and is used to determine the patient's perceptions of the severity of his or her disease in terms of medical consequences. Subjects were asked to respond to items on a 7-point scale ranging from *strongly agree* to *strongly disagree.* Reliability coefficients of the scales using Cronbach alpha (a measure of internal consistency) were .94 for the sickle cell sample and .84 for the diabetic sample.

Perception of Interference of Disease—This scale was developed for use in this study. These scale items were used to determine the degree to which patients perceived that their disease interfered with routine activities. Subjects were asked to respond to statements on a 7-point scale ranging from *interferes greatly* to *does not interfere at all.* Reliability coefficients (Cronbach alpha) of the scales were .85 for the sickle cell sample and .70 for the diabetic sample.

Symptom Checklist—This is a list of symptoms associated with the disease and was devised for use in this study. Subjects were asked to indicate the degree to which the following symptoms are a problem by responding to a 4-point scale ranging from *not a problem* to *a very serious problem.* The symptom checklist was different for the two groups. For the sample with sickle cell disease, the symptom checklist included the following: a) weakness and sluggishness; b) jaundice; c) irritability; d) nausea, vomiting; e) depression; f) excessive pain; g) swelling of hands and feet; h) poor eating, loss of appetite; and i) anxiety. The symptom checklist for the sample with diabetes included the following: a) sweating; b) excessive thirst; c) irritability; d) frequent urination; e) depression (feeling low, sad, moody, etc.); f) abdominal pain; g) skin rash; h) change in eating habits; i) anxiety; and j) problems with feet.

Acute Medical Treatment—Responses to these questions help determine the frequency of acute medical treatment. Subjects were asked to answer the following questions: 1) approximately how many times have you been hospitalized for sickle cell (diabetic) related problems? 2) Approximately how many times over the past two years have you gone to the emergency room for sickle cell (diabetic) related problems? Sickle cell patients were asked how many crises they had per year. Diabetic patients were asked how many episodes they had per year. (These episodes refer to hyperglycemic and hypoglycemic reactions where the blood sugar levels are above and below normal).

Procedure

Subjects were approached at their clinics while they waited to see a medical person. Their cooperation in participating in a study of the health care needs of patients was enlisted. They were asked to give their honest responses and confidentiality was assured. Interviewers assisted patients in completing questionnaires when necessary.

RESULTS

Composite measures were computed on all scale items. Pearson correlation coefficients were computed between the measure of social support and the following variables: a) perception of severity of disease, b) perception of interference of disease, c) symptom checklist, d) number of acute medical treatments, i.e. number of hospitalizations and emergency room visits, and e) number of crises (episodes).

Sickle Cell Sample

Social support was moderately but significantly associated with the number of hospitalizations ($r = .26$, $p < .05$), the number of emergency room visits ($r = .36$, $p < .01$), and the number of crises per year ($r = .32$, $p < .02$). High availability of social support was associated with fewer hospitalizations, fewer emergency room visits, and fewer

crises. Social support was not associated with the perception of disease severity, perception of interference of disease, or reported symptoms.

Diabetic Sample

Social support was significantly associated with the perception of disease severity ($r = .27$, $p < .01$), the perception of interference of the disease ($r = .22$, $p < .05$), and the number of symptoms ($r = .31$, $p < .01$). High availability of social support was associated with a less severe perception of disease, the perception that the disease did not cause as much interference with daily life, and fewer symptoms. Social support was not associated with number of hospitalizations, number of emergency room visits, or number of episodes per year.

DISCUSSION

The results of this study indicate that social support is associated with disease severity in black patients with sickle cell disease and diabetes. These moderate but significant relationships point to the importance of this variable in understanding the health needs of patients with sickle cell disease and diabetes.

A divergent pattern of relationships between social support and severity variables were found for patients with sickle cell disease and diabetes. Social support was more likely to be associated with behavioral outcomes, i.e. hospitalizations, emergency room visits, and crises for patients with sickle cell disease. High availability of social support was associated with fewer hospitalizations, emergency room visits, and crises. Social support was likely to be associated with perceptual variables for patients with diabetes. Patients with low availability of social support were more likely to report that they experienced more symptoms. This group perceived that their disease was severe and that the disease interfered with routine activities. It may be that these divergent patterns of relationships can partially be attributed to medical and demographic differences between the two samples.

Overall, patients with diabetes reported fewer hospitalizations or visits to the emergency room relative to patients with sickle cell disease. The responses of patients with diabetes also showed less variability compared to the responses of patients with sickle cell disease. The majority of the patients with diabetes reported none or only one emergency room visit or hospitalization for diabetic problems; sickle cell patients reported a range of one to more than ten hospitalizations and emergency room visits.

A similar response pattern emerged for the question about number of crises (episodes) per year. The majority of the patients with diabetes experienced no episodes (hypoglycemic/hyperglycemic reactions) during the specified time period. The responses from patients with sickle cell disease were more varied with reports of none to more than ten crises per year.

Patients with diabetes had a significant association between social support and the perception of the degree to which the disease interferes as well as perception of disease severity and symptoms. This association did not occur for patients in the other sample. The diabetic patients were much older (mean age was 57 versus 28). Social support may be especially important when considering severity variables in older patients. Elderly patients, especially those with a chronic illness, are more likely to need assistance. The availability of social support is more likely to directly benefit elderly patients than younger patients. For example, social support enables the elderly patient to engage in routine activities.

The divergent pattern of relationships between social support and disease severity variables of these two samples highlights the importance of a nonmonolithic approach for research with black populations. While severity variables were associated with social support for both groups, the nature of these relationships differed for the illnesses. The results of this study also point to the importance of using multidimensional measures when doing research. Behavioral and perceptional measures were used in this study.

Implications for Rehabilitation

The findings of this study are limited to black patients with sickle cell disease and diabetes. The role of social support in the health status of patients with other chronic illnesses and other ethnic groups is an area for further investigation. The findings from this study are applicable not only to the medical treatment process but to the total reha-

bilitative process. The perception of disease severity can be expected to be related to success or failure in rehabilitation efforts. Those individuals who feel that their disease is very serious and limiting will benefit less from rehabilitative services than those with less severe perceptions of their disability. In this context, social support can be thought of as a mediating variable affecting the relationship between the perception of disease severity and rehabilitative success.

Social support is also directly related to rehabilitative success (see papers by Miller and Wilson cited here). Those providing treatment and services to chronically ill or disabled black individuals must take into consideration social support systems and the availability of social support. When social support systems do not exist or are limited, directing the person to social support groups such as self-help programs and other community-based programs may be desirable.

SOCIAL SUPPORT AND SEVERITY OF DISEASE VARIABLE CORRELATES IN CHRONICALLY ILL BLACK PATIENTS

Variables	Sickle Cell	Diabetes
Perception of Severity of Disease	.15 p <.20	.27 p <.01
Perception of Interference of Disease	N.S.	.22 p <.01
Symptoms Checklist	N.S.	.31 p <.01
Number of times hospitalized over past two years	.26 p <.05	N.S.
Number of emergency room visits over past two years	.36 p <.01	N.S.
Number of crises (episodes) per year	.32 p <.02	N.S.
	N=47	N=63

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5 • Patients' Perceptions of Their Adjustment to Disability and Social Support in a Community-Based Teaching Hospital

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Abstract

This study was designed to determine if patients with family support and social work support adjust better to disability than patients without family support and social work support. Instruments were administered to the one hundred (100) black medical clinic patients participating in the study. The instruments included a) the Moors Family Environment Scale (which measures family support), b) the Handicap Problems Inventory (a measure of adjustment to disability), and c) the Brody Disability Score (which measures the level of the patient's disability). The instrument also contained demographic information as well as items measuring social work support. The results indicated that the social and family life areas of the Handicap Problems Inventory were significantly associated with the cohesion and expressiveness sub-scales of the Moors Family Environment Scale. The implications of the findings with respect to assisting the disabled in adjusting to their disability are discussed.

Society's negative attitudes toward deformity and disability have been a source of long standing concern among the disabled in America. Since modern medical science is responsible for people living longer, the possibility of disability faces an ever increasing number of Americans. Even though the needs and concerns of the disabled are receiving more attention at the federal, state, and local levels, changes in the political, economic, residential, educational, and health status of the disabled are made through legislative action and advocacy by the disabled and non-disabled.

It has been documented that disabled blacks experience even greater difficulty than disabled whites (Atkins, 1979). Socioeconomic and sociocultural factors such as low income level and racism further compound adjustment to disability.

Illness and physical disability are manifested to a greater degree among blacks than in the general population (Gary, 1982; Strauss, 1965). For example, the incidence of kidney disease and diabetes mellitus are more prevalent among blacks than among

whites. Black America also experiences a higher percentage of persons with elevated blood pressure as compared to the general population. The illnesses and disabling conditions cited above have contributed to noticeable differences in the death rate in the black community.

Counseling is critical to the treatment of patients diagnosed with hypertension, diabetes mellitus, and seizure disorders. This service is particularly important for the person's adjustment in all life areas. Negative attitudes and influences, both inside and outside of the disabled patient's community, strain the lives of the patient's family. The difficulties can only be handled by professional assistance geared towards maximizing one's ability to cope and function under such overwhelming circumstances (Johnson, 1962; Kaplan, 1967).

Broadening the definition of disability to include the disability diagnoses responsible for crippling the black community is an issue to be addressed. Expanding the definition could improve employment opportunities and eligibility requirements for benefits presently denied this group (Saad, 1969).

The purpose of this study was to investigate the relationship between 1) adjustment to disability and family support, 2) adjustment to disability and social work support, and 3) adjustment to disability and level of disability.

SUBJECTS

One hundred patients receiving medical services at Norfolk Community Hospital were identified for the sample. Subjects were selected via a proportionate, stratified random sample generated from the daily admissions list of the hospital. The sample was composed of males and females of various ages and marital status. It is important to note that sample size for the study was subject to realistic reduction in number because of the number of daily admissions to the hospital of patients fitting into the specific disability category.

DATA COLLECTION

Data were collected from the Norfolk Community Hospital. The Director of Admissions, the Director of Social Services, and two graduate students assisted the researcher with the data collection process.

The instrument consisted of three standardized scales. They were: the Handicap Problems Inventory (HPI), which is designed to assess the perception of adjustment to disability in personal, family, social, and vocational areas; the Family Environment Scale (FES), which was designed to tap the patients' perception of the significance of family support; and the Functional Disability Score (FDS), which was obtained in order to identify and categorize the level of disability. Additional demographic data were collected by means of a form developed by the researcher. All instruments were administered as soon as possible after admission, since the diagnosis may have limited whether administration could take place on the first or second day. The researcher reported to the Admissions Office and Social Service Department each day in order to include those patients admitted to the hospital and scheduled for early discharge.

All necessary provisions for confidentiality and protection of patients' rights were the same as those required by hospital policy.

SAMPLE

Descriptive statistics, i.e., frequencies, percentages, and measures of central tendencies were computed on all demographic variables. Sixty-four black female disabled patients and 36 black male disabled patients were included in the sample for the study. Sixty-seven percent of the patients were diagnosed as having hypertension. Thirty percent of the patients had primary diagnosis of diabetes mellitus and 3% of the patients had seizures disorders. Patients diagnosed with diabetes mellitus and seizure disorder may have had secondary diagnoses of hypertension.

The functional disability scores indicated that 93% of the sample population were moderately disabled, 4% of the patients were seriously disabled, and 3% were severely disabled.

Ages of the patients ranged from 16 to 83 with an average age of 53. Seventy-three percent of the patients had income levels of less than $3,000 per year. Three percent of the patients reported incomes in the $10,000 and above category. Forty-six percent of the

patients had less than an eighth grade education, 10% of the patients were high school graduates, and only 1% of the patients had attended college.

All of the 100 patients were receiving medical services from the hospital. Seven people received services from the occupational therapy department, and one diabetic patient reported in the "other" category designating services from the dental clinic, the nutrition department, and informal services from the clinic secretary (transportation, assistance with the hospital's system, etc.). Seventy-eight of the participants needed no mechanical or human assistance, though many in this group identified the need for and cost of medication as a concern. Six patients, however, required shoe braces, nine individuals used canes, five had walkers, and two required the use of hospital beds at home.

Of the sample, 36% reported that they lived alone, 8% lived with parents, 13% with non-relatives (friends, fiance, etc.), 13% lived with their children, and 10% lived with their spouse. Twenty percent of the subjects selected the "other" category designating other family members (aunts, uncles, cousins, godparents), facilities (boarding houses, rooming houses).

Sixty-six percent of the participants reported having an eligibility worker at a nearby community social services agency. The patients saw the worker at least once a year for a re-evaluation of their need for financial assistance, medical assistance, and food stamp services. None of the subjects reported receiving casework, group work, or family services from the community social service agencies. Four people did report using homemaker service and six people reported having home health service.

Sixty-seven percent of the subjects stated that no family member accompanied them to the clinic. Eighty-four percent of the patients reported that their relatives do not express concern about their diagnosis or medical needs. Eighty-eight percent of the subjects stated that no member of the family accompanied them to scheduled re-evaluation appointments with the eligibility worker to discuss concerns about medication costs, clinic transportation cost, stress of disability on family, etc.

The Handicapped Problems Inventory was used to measure adjustment to disability There are four subscales which measure adjustment in personal, family, social, and vocational areas of the patient's life. The mean scores on the personal, family, social, and vocational subscales were 77.0, 79.5, 73.6, and 48.3 respectively. The higher the score, the less adjusted were patients in these life areas.

The FES was employed to measure family support. The three subscales of cohesion, expressiveness, and conflict were used to measure the relationship dimensions of the family social environment. The mean scores for cohesion, expressiveness, and conflict were 69.4, 69.6, and 66.8 respectively. The mean scores for all three categories were high, yet not signicantly different from each other.

Social worker support was obtained by asking the patients questions pertaining to his or her perception of social work support. For the most part, patients did not receive social worker intervention except when an evaluation was done for Medicaid delineation.

DISCUSSION

The results of this study indicate that expressiveness as a measure of family support was significantly related to adjustment to disability as measured by the family and social life areas of the HPI. An expressive family environment was related to more problems in the area of family life. On the other hand, an expressive family environment was associated with fewer problems in the area of social life. This finding is consistent with the finding that scores for cohesion and conflict on the FES were both high. The patients participating in the study identified their ability to openly express themselves as being encouraged by their family members. During the interviews, it was a common response for patients to identify specific disagreements, concerns, problems, and conflicts faced by them and their family members caused by the disabling situation. In spite of these concerns and difficulties (e.g. financial, fears, myths, confrontations), the patients felt that their family members were still supportive as they faced their hostile environment. Contacts with family members, even when limited, were verbalized as a positive and stable supportive force in the patient's life. These types of

contacts and interactions affect the disabled person's adjustment to his or her disability.

The *Pearson Correlation Coefficients* were computed between the four areas comprising the HPI and the subscales comprising the FES (See Table I).

The family life area of the HPI was significantly related to the expressiveness scale of the FES with high scores on the measure of expressiveness. The measure of social life areas of the HPI was negatively related to the expressiveness measure of the FES.

The family life area of the HPI was significantly correlated with the cohesiveness subscale of the FES in the negative direction ($r = -.32$ DL.051). High scores in the family and social life areas of the HPI were associated with low scores on the measure of cohesion.

Social work support was not significantly related to adjustment to disability in any of the four areas of the HPI. Level of disability was also not related to adjustment to disability. Cohesion as a measure of social support was also significantly related to the family and social life areas of the HPI. Low family cohesiveness was associated with a less favorable adjustment to disability. These measures of family support, i.e., expressiveness and cohesion point to the importance of understanding these variables when assisting persons in adjusting to their disability.

A significant relationship between perceived adjustment to disability in all life areas and social work intervention was not found. The patients did identify having annual evaluations regarding their financial status. However, the patients and their family members did not participate in any case work or group work services. There was no identified work with families or intervention on their behalf with health professionals. Consequently, the missing service is still considered valuable though statistical significance is impossible to achieve with no member of the sample receiving comprehensive intervention from a social worker.

It is important to note that no statistically significant relationship was found between the level of disability and adjustment to disability. However, the categories of level of disability were small since 94% of the patients fell into the moderately disabled category. The patients were active in the medical treatment program and medications were identified as essential in helping them to physically function and to participate in daily living activities.

It is important to mention that patients had low adjustment scores in all areas except vocational adjustment. This vocational adjustment score is attributed to the patients' perception that employment was difficult, if not impossible, to obtain. Consequently, the patients regarded other opportunities (e.g. yard work, odd jobs, babysitting, church work) in the employment or vocational adjustment category. Additionally, the medical clinic staff felt that current vocational programs found their patients ineligible for services and training opportunities because of prescribed disability definition and the nature of the symptoms experienced by the patients (Smith, 1978).

TABLE 1

PEARSON CORRELATION COEFFICIENTS

	HPI-Personal	HPI-Family	HPI-Social	HPI-Vocation	FES-Cohesion	FES-Expressiveness	FES-Conflict
HPI-Personal	1	0	0	0	−0.1628	−0.1815	0.0131
HPI-Family			0	0	−0.2078*	0.2618*	−0.0522
HPI-Social				0	−0.3235*	−0.1979*	−0.0378
HPI-Vocational					−0.0618	−0.1857	−0.0581

NOTE: P = <.05

RECOMMENDATIONS

Further studies are needed in order to identify the specific concerns preventing successful adjustment to disability among black disabled persons. Additional information to ascertain the extent of the available services to this group by rehabilitation and health agencies needs to be identified. Current rehabilitation and health agencies should maximize the opportunities of the black disabled currently receiving services by identifying gaps that might prevent the patient's chances of being a more productive member of society.

The training of health professionals should include sensitizing society to the unique concerns and the situations of the black community. This is especially necessary since the disabled population needs more active advocates to influence those who make policies affecting the disabled population's plight.

The investigator recommends that similar studies like the one presented here be replicated in other agencies and facilities. It is suggested that additional comparison groups be used. For example, the responses from black and white disabled groups could reveal important information as they compare and contrast their disabling situation.

While this study addressed disabled adults, it is especially important to recognize the high number of disabled children and youth who require the professional services of health/rehabilitation workers and who also suffer from the negative social attitudes in regards to deformity and disability.

The training of more social work practitioners in all areas of social work practice is felt to be essential. Training in family intervention and the use of family as resources are recommended.

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6 • Frequency and Distribution of Disabilities Among Blacks: Preliminary Findings

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Abstract

The present study was designed to identify and assess the frequency, distribution, and impact of various disabilities among black Americans. Twenty-seven (27) agencies—8 state and 19 private—from the following targeted cities comprised the sample: Washington, DC; Atlanta, GA; New York, NY; Gary, IN; Los Angeles, CA; Little Rock, AR; Detroit, MI; and Jackson, MS. The research findings clearly substantiate evidence of some unique features of the status of black disabled individuals. Selected disabilities analyzed, using cross tabulations and chi-square statistics, suggest significant clusters of black clients only as the comparison relates to the distribution of blacks in the larger population of the designated areas. When analyzed across ethnic groups, the percentages of these disabilities for whites exceed those for blacks by 200% and sometimes 300%. Also, when the contrast is based on ethnic group membership across all regions, only sickle cell anemia is significantly more prevalent among blacks, and there is greater variability with regard to the incidence of disability and ethnicity-based regional distribution. Other findings relative to earnings and mental retardation, together with the delivery of services to blacks, call attention to the need for further investigation and for remediation.

BACKGROUND

While it is true that handicapped individuals who are members of racial and ethnic minorities suffer the same indignities as other handicapped individuals, there are special and unique problems that these individuals face because of the lack of awareness of their cultural differences (Stedman, 1977). In addition, prejudice and racial discrimination continue to exclude a great number of minorities (particularly blacks) from full participation in all aspects of society (Stedman, 1977; Bowe, 1983; Walker et al., 1984).

The problem of black handicapped individuals is indeed complex. Not only do blacks have to live with excessive economic burden, but education is frequently not available to them. As a result, they have fewer opportunities for education and for earning decent incomes. Moreover, access to their homes, stores, schools, transportation, and the general community facilities can only be achieved through the use of extreme measures and often with the involvement of at least another person (Miller, 1984).

Merton Gilliam (1981) gives firsthand examples of prejudices he has experienced as a double minority (i.e. being black and handicapped). Gilliam said he grew up in the black ghetto of Cincinnati during the Depression and was constantly subjected to pressures and criticism in public schools. In his quest for employment, he suffered humiliation and

rejection. "Nobody wanted to hire a guy on crutches; employers claimed that they would have insurance problems," he tells us.

During his college years, Gilliam observed that, of the 80 disabled students who were sponsored by rehabilitation or other programs, blacks received the least services:

> Public transportation was not available to the physically handicapped who used wheelchairs and crutches, and the cost of special transportation was excessive. The few facilities that are available to the handicapped are frequently set apart so that the individual has to be treated as a special case.

Clearly, the need for research which responds to the needs of minority populations with handicapping conditions has been substantiated. Evidence that minority populations (blacks in particular), have unique handicapping problems and have been inadequately served in rehabilitation programs is overwhelming (National Institute of Handicapped Research, 1981).

However, no comprehensive research has been conducted to indicate the number of handicapped individuals within the black population and to identify these unique needs. It is essential that research strategies be implemented which begin to address problems and issues specific to the successful rehabilitation of disabled minorities.

METHODOLOGY

Purpose

This study, along with two other research investigations, was designed to establish empirical research as a means of identifying and assessing the frequency, distribution, and impact of various disabilities among black Americans. The emphasis here is the identification and delineation of significant clusters relative to the rehabilitation status and needs of blacks as compared to other ethnic groups within eight select geographic areas of the United States.

The profile and results embodied in this research report cover only the initial elements of the study. More comprehensive reports will be given subsequently.

Description of Participating Agencies

Initiated during the 1983-84 project year of the "Howard University Model to Improve Rehabilitation Services for Minority Populations with Handicapping Conditions," this study examined disability distribution in a selected sample. Table I contains a profile of the 27 agencies comprising this selected sample based on predetermined research sites which constitute regional representation. The following cities were the targeted sites: Washington, DC; Atlanta, GA; New York, NY; Gary, IN; Los Angeles, CA; Little Rock, AR; Detroit, MI; and Jackson, MS. The rationale for this selection is that a substantial number of blacks reside in these cities. It should be noted that the sample population represents agencies and clients within the larger metropolitan areas within up to a one-hundred-mile radius.

See Table II for ethnic population distribution in the respective metropolitan areas (these figures were taken from the 1980 Population Census).

Data were collected during the period January to October 1984 via a survey format through the utilization of a two-part questionnaire which included three appendices. The questionnaire was mailed out to respondents. Eight public and 19 private agencies participated in this study. The total client population was approximately 282,000, which constitutes 87% for state agencies and 13% for private agencies. This statistic reflects some duplication since many public agencies often contract out clients to private agencies after evaluation. The ethnic composition of the sample is 36% black, 56% white, and 8% for other ethnic groups.

General Design and Analysis

The research instrument consisted of a two-part, twenty-four item questionnaire developed and validated through the cooperation of rehabilitation professionals from the following groups: the project's National Advisory Committee, the Local Task Force (which consists of representatives from agencies in the District of Columbia metropolitan area), and the Research Committee of the Council of State Administrators of Vocational Rehabilitation.

Types of Analyses

Part I of the questionnaire generated descriptive information on agencies surveyed, including staffing and types of services provided. These descriptive character-

TABLE I

AVERAGE CASELOAD OF AGENCIES PARTICIPATING IN NATIONAL SURVEY

LOCATION	PRIVATE PARENT ORGANIZATION	NO. OF COUNSELORS	NO. OF CLIENTS	AVG. CASELOAD
Arkansas	Department of Human Services	132	3345	93
California	Human Resources Center	4	700	100
California	Parent Auxiliary	1	15	17
California	Parent Auxiliary	1	50	50
California	Parent Auxiliary	8	55	6
California	State of California	635	93589	148
District of Columbia	Department of Human Services	69	13507	200
Georgia	Department of Human Services	3	199	30
Georgia	Department of Human Services	82	12144	148
Indiana	———	148	22644	153
Michigan	League—Goodwill	3	434	15
Michigan	League—Goodwill	217	16381	96
Michigan	League—Goodwill	635	93589	148
Michigan	Michigan Rehab. Services	16	844	67
Michigan	Michigan Rehab. Services	20	144	80
Michigan	Michigan Rehab. Services	47	3941	111
Michigan	Jewish Volunteer Services	4	345	25
Michigan	Jewish Volunteer Services	7	167	19
Mississippi	Department of Human Services	86	24203	281
New York	Assoc. for Chn. W/Ret. M/Dev.	30	1000	20
New York	Department of Education	—	74725	—
New York	Federation of Jewish Phil.	22	1015	25
New York	Federation of Jewish Phil.	29	435	15
New York	Vera Ins. of Justice, Inc.	6	153	20
New York	Health & Hospital Services	—	—	—

TABLE II

ETHNIC DISTRIBUTION IN THE TARGETED AREAS ACCORDING TO THE 1980 POPULATION CENSUS

CITIES	BLACKS NO.	%	WHITES NO.	%	TOTALS
Atlanta, GA	498,826	24.5	1,508,640	74.3	2,029,710
Detroit, MI	890,532	20.45	3,376,800	77.5	4,353,413
Gary, IN	126,350	19.65	491,274	76.4	642,781
Jackson, MS	126,202	39.3	192,547	60.0	320,425
Little Rock, AR	82,865	21.0	306,058	77.7	393,774
Los Angeles, CA	943,968	12.6	5,073,617	67.8	7,477,503
New York, NY	1,940,628	21.27	6,117,497	67.07	9,126,346
Washington, DC Metro Area (SMSA)	853,719	27.8	2,072,934	67.7	3,060,922

* Census Bureau
Suitland, MD
763-5002

istics were examined across state and private agencies with cross-tabulations. Part II of the research instrument facilitated the collection and analysis of the following types of data: a) the frequency of various types of disabilities and b) a comparison of client earning levels at referral and closure. Utilization was also made of a chi-square statistical measure in the anaylsis of data.

Research Questions

1. With reference to the descriptive characteristics of the sample surveyed, (a) how many clients were served in the respective agencies for Fiscal Year 1983, and what was the average caseload per counselor? (b) what types of services were provided? (c) what was/were the principal source(s) of funding?
2. What is the ethnic breakdown of the sample populations?
3. Of the 18 identified disability groups, which ones, if any, are significantly more prevalent among blacks than among whites?
4. Are there significant differences, based on ethnicity, with respect to these 10 selected disabilities?
   - Blindness
   - Diabetes
   - Orthopedic Impairment
   - Sickle Cell Anemia
   - Amputee
   - Epilepsy
   - Substance Abuse
   - Cardiovascular Diseases
   - Mental Retardation
   - Visual Impairment
5. What percentage of the total sample constitutes mental retardation for all ethnic groups in both private and public agencies?
6. Is there a relationship between disability and ethnicity with respect to regions?
7. What is the level of earnings of clients at referral and closure by ethnicity?
8. Given the five regions:
   West: California
   Midwest: Michigan, Indiana
   Mid-Atlantic: Washington, DC
   Northeast: New York
   South: Georgia, Mississippi, Arkansas
   where are the most significant clusters in the 10 major disabilities for nonwhites located?

Results

An analysis of Part I of the survey instrument yielded descriptive characteristics of the sample (including staff personnel, clients served, types of services provided) which are as follows:

1. Eight public and 19 private agencies showed a grand total of over 1,660 counselors (not including New York State) and 282,000 clients served during the 1983 fiscal year. Of these, the public agencies account for 70% of the counselors and 87% of the clients served. Table I gives a more detailed breakdown of these variables and their respective frequencies. Much of the data from New York State and Harlem Hospital are currently being further analyzed; therefore, all of the findings are not fully reported. The remaining data will be included in a subsequent report to be given at a later date.
2. State agencies located in larger, more highly populated states carry proportionately larger clientele. Examples are, the State of California with approximately 94,000; New York State, 74,725; Mississippi, 24,000; and Indiana, 23,000. Georgia and the District of Columbia also have relatively large clientele—some 12,000 and 13,500 respectively. (See Table I.)
3. With respect to average caseload per counselor, private agencies seem to have an advantage. For instance, private agencies have a grand mean of 48 clients per case worker. That is, over 300% fewer. It must be noted, however, that these 156 clients might constitute a spurious statistic, since state agencies often contract out services to private agencies so that clients are often included in state agency intake and after evaluation, they are then referred to private facilities for the provision of specific services such as training. Private agencies include organizations such as Goodwill Industries and the Association for Retarded Citizens.

Another variable was the primary source of funding for the respective agencies. These represent three principal types: state-federal matchings, state-supported and private contributions. As might be expected, all eight public agencies fell under the category of

state-federal matchings. For the private agencies, there is a great deal of overlap since many of these agencies get their financing from combined sources. For instance, as many as 56% of the agencies reported support from state-federal matchings. Yet, many of these are also represented in the 33% financed by private contributions and also in the 39% receiving contributions from sources other than the three mentioned above. (See Table III.)

A detailed examination was also made with respect to the types of agencies serving disabled populations in the targeted areas as well as the services offered. Tables IV and V contain an overview of these data. Pre-eminent among the types of agencies are vocational, vocational rehabilitation, educational, social service, mental health, private and non-private residential and nonresidential, non-profit and independent living centers. The types most frequent in our sample are vocational (12%), vocational rehabilitation (23%), educational (6%), non-profit (12%), and private (9%). (See Table IV.)

The data reflect the delivery of a wide range of services. The following are among the most frequent types of services provided by the participating agencies: medical diagnosis and treatment, psychological diagnosis and treatment, psychiatric diagnosis and treatment, vocational and educational counseling, peer counseling, academic reinforcement, vocational assessment, occupational and physiotherapy, job training and placement. A large number of agencies also provide vocational assessment (i.e. 21 agencies, or 78%, offer this type of service). Consistent with this, there are a similarly large number of agencies offering job training; for example, 70% of our sample offer this service and 56% provide job placement. With reference to vocational education and counseling, another 56% offer academic reinforcement (see Table V for further breakdown.)

In Section II (of the research instrument), selected disabilities analyzed by ethnic groups reveal some interesting contrasts. Of the 18 disability categories listed in the survey questionnaire, the categories with the largest number of clients were "other" totaling 20,844 (this category includes clients with multiple handicaps) and "mental retardation" totaling 18,114. Of the mentally retarded clients, 14,727 were served by state agencies and 3,831 were served in private agencies. (Mental retardation represents clients clearly identified as mentally retarded—approximately 13% of the sample population. Nevertheless, it must be stated that it is likely many of the clients identified under the "other" category may also be mentally retarded, since this category includes the multiply handicapped.) The data show that 6,989 of the 14,727 mentally retarded clients (48%) in the public agencies were black. Similarly, 1,919 of 3,836 mentally retarded clients (50%) in the private agencies were black (See Table VI). A similar pattern was shown for whites. Mental retardation was 48% and 41% respectively for state and private agencies.

Other major disabilities showing significant clusters for nonwhite groups in public agencies are blindness (32%), sickle cell anemia (95%), orthopedic impairment (25%), substance abuse (30%), and cardiovascular disease (30%). Amputee, diabetes and epilepsy also represent proportionate clusters for blacks and other minorities. It should be noted, however, that while each of the disabilities cited is significantly high among blacks, sickle cell anemia is the only one which has a lower rate of manifestation among white clients in the sample. In response to research question 3, of the 18 disability groups selected for the sample, only sickle cell anemia is more prevalent among blacks than among whites when the comparison is based on ethnic group membership across all regions. However, the data bears out a positive answer to research question 4, since the significant differences in the prevalence of disability do exist based on ethnicity.

With respect to the most significant clusters in the 10 major disability groups across state and private agencies, in response to research question 4 (Is there a relationship between disability and ethnicity with respect to region?), the following results were observed: Table VI indicates that sickle cell anemia, mental retardation and cardiovascular disease all have significant clusters across state and private agencies. Blindness, diabetes, amputee and substance abuse (all in the 30 to 30+ percentage range) suggest significant clusters also. This, however, is reflective of the distribution of blacks in the sample population which is 36%. All of the other disabilities named in research

TABLE III

I YPE AND SOURCE OF SUPPORT FOR AGENCIES PARTICIPATING IN NATIONAL SURVEY

TYPES OF AGENCIES	FEDERAL/STATE MATCHING		STATE SUPPORTED		PRIVATE CONTRIBUTIONS		OTHER	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
State = 8	28	100						
Other = 19	10	56	6	33	6	33	7	39

TABLE IV

PROFILE OF SAMPLE AGENCY CATEGORIES

TYPE OF AGENCY	AGENCIES					
	STATE AGENCIES		PRIVATE AGENCIES		OTHER	
	Number	Percent	Number	Percent	Number	Percent
Correctional	0	0	0	0	0	0
Educational	0	0	6	100.0	6	6.7
Government	4	80.0	1	20.0	5	5.6
Hospital	1	100.0	0	0	1	1.0
Independent Living Center	1	20.0	4	80.0	5	5.6
Mental Health	0	0	5	100.0	5	5.6
Non-Private	1	50.0	1	50.0	2	2.2
Non-Profit	0	0	0	0	0	0
Non-Residential	1	25.0	3	75.0	4	4.5
Private	0	0	9	100.0	9	10.1
Profit	0	0	0	0	0	0
Residential	1	20.0	4	80.0	5	5.6
Social Service	0	0	6	100.0	6	6.7
Vocational	1	16.7	5	83.3	6	6.7
Vocational Rehabilitation	7	30.4	16	69.6	23	26.0
Total	18		71		89	100.00

TABLE V

SUMMARY OF TYPES OF SERVICES OFFERED BY SAMPLE AGENCIES

TYPE OF SERVICES	AGENCIES					
	STATE AGENCIES		PRIVATE AGENCIES		OTHER	
	Number	Percent	Number	Percent	Number	Percent
Academic Reinforcement	4	27	11	73	15	6
Independent Living	5	36	9	67	14	6
Job Placement	6	40	9	60	15	6
Job Training/Ret	7	37	12	63	19	8
Medical Diagnosis	6	55	5	45	11	5
Medical Treatment	6	67	3	33	9	4
Occupational Therapy	5	50	5	50	10	4
Peer Counseling	3	33	6	67	9	4
Physical Therapy	5	63	3	37	8	3
Psychiatric Diagnosis	6	60	4	40	10	4
Psychiatric Treatment	6	46	7	54	13	5
Psychology Diagnosis	6	43	8	57	14	6
Psychology Treatment	6	46	7	54	13	5
Recreation Facilities	5	45	6	55	11	5
Social Work	1	10	9	90	10	4
Transportation	6	43	8	57	14	6
Other	2	40	3	60	5	2

question 2 are also proportionately significant (see Table VI).

It is important to note, however, that these percentages constitute significant proportions only as they relate to the distribution of blacks in the sample and in the larger population of the designated areas. When analyzed across ethnic groups, the percentages of these disabilities for whites are two and sometimes three times the proportion for blacks. Examples of these phenomena are reflected in the fact that among the blind, 32% were black and 56% were white. Likewise, of the substance abuse clients, 30% were black and 61% were white. Another example of these comparisons is the fact that in public agencies epilepsy was 28% among blacks and 64% among whites. (See Table VI for review of these data.)

While this pattern of concentration of black handicapped clients seem to be characteristic of the sample for most regions (West, Midwest, and Northeast), for most of the disability clusters reported above, there are several exceptions however. The chi-square statistical procedure showed a significant relationship (above and beyond the .01 level) between disability and ethnicity with respect to the regions from which the sample was drawn (see Table VII). The pattern of disability in relationship to the clients' ethnicity was less consistent for the Southern and Mid-Atlantic regions than for the other three regions.

An examination of Table VII for the West, Midwest, and Northeast regions, reveals similar ratios of the incidence of visual impairment, amputee, and epilepsy between blacks and whites to those found in Table VI for the overall sample. However, there is greater variability with regard to the incidence of disability and ethnicity based on regional distribution. For example, mental retardation in the Southern region is reported as 69% among blacks as compared to 28% among whites (whereas it was reported as about equally distributed within the overall sample for both public and private agencies). Visual impairment is reported as being about three times as high among blacks in the Mid-Atlantic and Southern regions. This pattern was reversed in the overall sample. Likewise, substance abuse is reported to be 70% among blacks as compared to 23% among whites in the Midwest. The Mid-Atlantic region reported overwhelmingly high proportions for blacks for each of the disability categories.

With reference to the economic status of clients at referral, the data indicate that generally, as the income levels increase, the percentage of blacks in the respective categories decreases. Further, some 32,410 of the 109,142 (or 30%) of clients with no earnings are black (see Table VIII). With respect to earnings of clients at closure, the data show some marginal decrease across all ethnic groups (except blacks) in the no income category. The percentage of blacks in this category went up by 2%. However, there is a significant upward trend in the percentages at the higher income levels for black clients. For instance, in the less than $50 per week category, the percentage of blacks dropped from 29% at referral to a mere 5% at closure, while in the $200 + category, the percentage rose from 12% to 15%. (See Tables VIII and IX for these comparisons.)

DISCUSSION

The study clearly has substantiated further evidence of some unique features of the status of black disabled individuals. Indeed, there are important findings that call attention to further examination and perhaps remediation.

The current study provides an overview of the types and level of rehabilitation services in eight metropolitan areas throughout the United States. The findings include a profile of eight public and 27 private agencies. It also provides comparisons of the distribution and frequency of disability among the sample population. An analysis of 1980 census data reveal the incidence of disability among blacks in the general population to be almost twice as high among blacks as it is among whites—14% as compared to 8% (Bowe, 1983). However, the breakdown of disability among the clients in the current study in the majority of the categories identified for the study, with the exception of mental retardation (which was almost evenly distributed) and sickle cell anemia (which was found almost exclusively among blacks), was reported at levels two or three times higher among whites than blacks. It was noted, nevertheless, that a large number of blacks were identified under the other categories which included multiple handicaps. The distribution of various disabilities by

TABLE VI

NUMBER AND PERCENT OF CLIENTS FOR SELECTED DISABILITIES
BY ETHNIC GROUPS

DISABILITY	STATE AGENCIES								PRIVATE AGENCIES							
	BLACK		WHITE		HISPANIC		OTHER		TOTAL	BLACK		WHITE		HISPANIC		OTHER		TOTAL
	N	%	N	%	N	%	N	%		N	%	N	%	N	%	N	%	
Amputee	539	33	919	57	89	6	65	4	1612	93	44	100	49	2	1	14	7	209
Blindness	1273	32	2201	56	216	6	248	6	3936	234	35	281	42	-	-	158	23	673
Cardiovascular	1302	36	2022	57	106	3	152	4	3582	234	46	214	42	23	5	34	7	505
Cerebral Palsy	249	26	647	68	36	4	17	2	949	33	31	63	60	5	5	4	4	105
Diabetes	394	33	708	59	61	5	47	4	1210	62	44	70	49	2	1	8	6	142
Digestive Disorders	615	36	1054	61	38	2	25	1	1732	67	52	59	45	1	1	3	2	130
Epilepsy	560	28	1285	64	126	6	45	2	2016	111	41	146	54	8	3	5	2	210
Hearing Impairment	1018	20	3398	67	313	6	330	7	5059	227	33	362	53	25	4	68	10	682
Learning Disabilities	598	26	1437	63	216	10	26	1	2277	188	37	308	69	16	3	1	-	513
Mental Illness	3160	22	10038	70	685	5	393	3	14276	402	18	1494	66	214	10	142	6	2242
Mental Retardation	6989	48	7035	48	384	3	319	2	14727	1919	50	1558	41	215	5	144	4	3835
Orthopedic Impairment	5143	25	13617	67	1196	6	524	3	20480	706	43	779	49	35	2	89	6	1629
Respiratory Conditions	264	35	433	57	36	5	33	4	766	30	30	54	55	4	4	11	11	99
Sickle Cell Anemia	238	92	10	4	-	-	10	4	258	43	90	-	-	-	-	5	10	48
Speech Impairment	158	33	258	54	52	11	10	2	478	23	31	45	61	3	4	3	4	74
Substance Abuse	3278	30	6559	61	739	7	201	2	10777	371	35	667	62	1	0	31	3	1070
Visual Impairment	246	24	618	61	111	11	36	4	1011	60	25	158	67	9	4	9	4	236
Other	9499	55	5738	33	474	3	1683	10	17398	1413	43	1513	49	9	3	158	5	3095

TABLE VII

SIGNIFICANT CLUSTERS IN THE MAJOR DISABILITY GROUPS ACROSS REGIONS
(STATE AGENCIES ONLY)

DISABILITY		WEST: CALIFORNIA				MIDWEST: INDIANA				MID-ATLANTIC: DC				NORTHEAST: NEW YORK				SOUTH: GA, ARK., MISS.			
		B	W	H	O	B	W	H	O	B	W	H	O	B	W	H	O	B	W	H	O
Blindness		321	1043	197	48	82	82	9	1	238	31	5	30	26	68	—	2	608	161	5	168
	%	20	65	12	3	47	47	5	1	78	10	2	10	27	71	—	2	64	18	1	18
Visual Impairment		40	124	105	10	2	9	3	—	69	5	2	12	20	121	—	2	165	359	1	11
	%	14	44	38	4	14	64	21	—	78	6	2	14	14	85	—	1	31	67		2
Ortho. Impairment		1006	4225	1165	222	100	96	12	—	745	29	19	123	936	4722	—	52	2356	4545	—	127
	%	15	64	18	3	48	46	6	—	81	3	2	13	16	83	—	9	34	65	—	2
Amputee		62	197	84	22	9	14	3	0	79	2	2	11	97	299	—	13	292	406	—	19
	%	17	54	23	6	35	54	12	—	84	2	2	12	24	73	—	3	40	57	—	3
Substance Abuse		641	1872	734	43	39	13	3	0	986	80	8	89	591	1397	—	19	1021	3197	5	50
	%	20	57	22	1	70	23	6	—	85	7	6	8	29	70	—	1	24	75	.1	1
Mental Retardation		486	995	365	31	51	36	5	—	624	55	10	67	1371	4063	—	41	4687	1886	4	180
	%	26	53	19	2	55	39	5	—	83	7	1	9	25	74	—	1	69	28	.5	5
Sickle Cell Anemia		50	1	—	1	9	1	—	—	40	1	—	4	55	8	—	0	84	—	—	6
	%	96	2	—	2	90	10	—	—	89	2	—	9	87	13	—	—	93	—	—	7
Cardiovascular		171	439	106	30	14	13	0	1	360	4	5	81	193	679	—	3	564	88	—	51
	%	23	59	14	4	40	46	—	4	80	.8	.1	18	22	78	—	.3	38	60	—	3
Epilepsy		88	317	126	15	19	16	—	—	52	6	3	15	132	641	—	5	209	305	—	5
	%	16	58	20	3	54	46	—	—	68	8	4	20	17	82	—	1	40	58	—	2
Diabetes		54	167	58	9	6	9	—	—	108	2	3	24	72	319	—	2	154	213	—	12

TABLE VIII

EARNING STATUS OF CLIENTS AT REFERRAL BY ETHNIC GROUP
ACROSS STATE AND PRIVATE AGENCIES

MEAN WEEKLY INCOME	BLACK	%	WHITE	%	HISPANIC	%	OTHER	%	TOTAL
No Earnings	32410	30	69351	64	4215	4	3166	3	109142
Less than $50	316	29	724	65	37	3	32	3	1109
$50–$99	472	26	1288	70	35	2	52	3	1847
$100–$120	358	38	541	57	29	3	17	2	945
$151–$199	146	22	496	74	10	2	19	3	671
$200 +	281	12	2115	87	40	2	3	1	2439

TABLE IX

EARNINGS STATUS AT CLOSURE BY ETHNIC GROUPS
ACROSS STATE AND PRIVATE AGENCIES

MEAN INCOME WEEKLY	BLACK	%	WHITE	%	HISPANIC	%	OTHER	%	TOTAL
No Earnings	6378	32	12183	62	731	4	410	2	19702
Less than $50	639	5	12419	94	16	.1	23	.2	13097
$50–$99	618	25	1722	71	75	3	26	1	2441
$100–$125	423	3	872	62	80	6	25	2	1400
$126–$150	1535	30	3322	65	199	4	57	1	5113
$151–$199	748	22	2378	71	188	6	39	1	3353
$200 +	1016	15	4745	71	406	6	523	8	6690

ethnicity was similar for public and private agencies. On the other hand, there was a great range of variability with regard to the distribution of disability and regional representation. Much higher proportions of visual impairment (64% blacks versus 18% whites) and mental retardation (69% blacks versus 28% whites) were reported in the Southern region. These findings suggest the need for regional planning related to the delivery of services. It should be noted that Bowe (1983) reported that 50% of the black disabled reside in the Southern area of the United States.

At both levels—state and private—the percentage of whites receiving services was twice and sometimes three times as many as blacks, and this is viewed against the fact that the percentage of blacks and whites in the sample is 36% and 56% respectively. A review of the results suggests that within each of the regions surveyed, a wide array of supportive services exist, yet the proportion of black clients enrolled is lower than would be expected by chance.

The findings of the current study are consistent with those of Robinson (1979). He reported a high proportion of mentally retarded clients within the rehabilitation service system. The single disability category in the current sample in which both blacks and whites were closely matched with regard to proportion for incidence of disability is mental retardation. (This is true within both the public and private agencies.)

Further research into the possible causes, and a more comprehensive analysis of all related data, will help to suggest ways and means of addressing the imbalances. One possible cause is the fact that blacks may not be seeking out and taking full advantage of available facilities.

Another finding that suggests implications which warrant further examination is the fact that even after the rehabilitation process, a disproportionately large number of blacks still remain in the lower income groups, with only marginal increases in the number of clients as the income categories move to higher levels. Because income is usually tied to levels of educational attainment and socio-economic status, it seems quite obvious that the academic and technical skills of the black client population need to be up-graded.

Findings from the current study are consistent with those of Atkins (1980) since she also found that blacks seemed to benefit to a lesser degree than whites as a result of going through the rehabilitation process. It must be emphasized here that the current study is part of a larger study; therefore, these data must be interpreted in that light. Two major implications from the current analysis are the need for a) a close examination of regional variations and b) linkages and communication among various service agencies, community organizations, and educational facilities.

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7 • Critical Vocational Rehabilitation Service Delivery Issues at Referral (02) and Closure (08, 26, 28, 30) in Serving Select Disabled Persons

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Abstract

This pilot study revealed that the traditional vocational rehabilitation (VR) model appeared to be responding to and impacting on white clients in predictable and consistent ways; its impact on nonwhite clients was consistently different from that of white clients. The more salient findings were as follows: (1) the rank order referral pattern for the top five referral sources showed that "Self" was the primary referral source for *all* clients and that the top five referral sources remained the same for 1982 and 1983 for white clients while that for nonwhites shifted for referral sources occupying positions 2-5 between 1982 and 1983. The shift in rank order of referral sources demonstrated an increasing impact of educational institutions and social security and public sources on nonwhites "entering" the VR system; (2) on "exiting" the system, "refused services" was the primary reason for closure in 1982 and 1983 for white clients while "failure to cooperate" more often predominated as the primary reason for closure for nonwhite clients in 1982 and 1983; and (3) the data revealed that whites made up a greater proportion of Status 26, or competitive closures, in 1983 while nonwhites received a higher proportional representation than whites among those closed in non-rehabilitated closures (Statuses 28 and 30). This pilot study was effective in heightening the agency's awareness of a number of issues regarding outreach and VR outcomes for nonwhite clients.

BACKGROUND

It has been generally accepted that nonwhite disabled individuals have not had equal access to vocational rehabilitation services. This mirrors the exclusion of nonwhites in many aspects of the dominant American culture. On the other hand, the lack of equal access is attributable to the adverse impact of strongly held cultural values of minority populations. In either case unequal access to vocational rehabilitation services portends the need to assess the nature of the problem. We need to ask: What is the nature of nonwhite access to the vocational rehabilitation service delivery system, and what is the nature of placements and/or outcomes for this select group of vocational rehabilitation clients?

Traditionally, it has been assumed that as the vocational rehabilitation program was designed for the disabled, it was sufficient to meet the needs of all of the disabled. However, experience has taught us that programs and systems developed for the normative and/or dominant culture do not necessarily meet the needs of minority disabled persons. There is growing evidence that while minority disabled persons have problems which are similar to those of the dominant culture, the problems they face may differ both in scope and in magnitude. For example, as a result of a five-year landmark study on the readiness of the severely handicapped to use vocational rehabilitation services on leaving high school which was conducted by the New York State Office of Vocational Rehabilitation (NYS/OVR) in collaboration with the New York City School Board (1968), Neff and his associates concluded that "the ethnic and socio-economic

status of the children (and of their families) were very important determiners of both progress and outcome" and that "prevocational service appears to be least effective when the handicapped child is also faced by all the manifold problems of the subculture." In a similiar manner, Cohen & Hodges (1963) pointed out that the poor are relatively helpless and impotent in manipulating the institutions of society to fulfill their needs and are generally convinced that they are unable to influence the workings of society. This statement is equally true of the disabled generally and of the minority disabled particularly.

In short, though significant progress has been made in the passage of legislation to improve the status and protect the rights of nonwhite disabled persons and in improving services to nonwhites, many problems in service access by and service provision to nonwhites remain.

Our review and analysis of the literature descriptive of the nonwhite population within New York State and nationally shows that within New York State approximately 7.7% of all working age residents are disabled. Of that number, "... black males represent 15.7% of all disabled males in the state of working age while black females comprise 21.0% of all disabled females between the age of 16 and 64. One in eleven or 8.9% of all disabled working age New Yorkers is of Hispanic origin" (Bowe, 1984). Thus, these two minority groups alone would comprise 45.6% of the total disabled population in New York State.

As of December 1983, the NYS/OVR was providing services to the disabled population in the following proportions: 76% white, 13% black, and 9% Hispanic. The active caseload in August 1984 consisted of 79% white, 19% black, less than 0.5% Indian/Alaskan native and 19% other. The apparent discrepancy between the percentage of nonwhite disabled persons in New York State and the percentage of these persons being served by NYS/OVR, indicates the need for a greater effort by the New York Vocational Rehabilitation agency to reach out to nonwhite populations within the state. For example, on the national level, Frank Bowe (1984) has shown that "disability is markedly more common among blacks (adults) than it is among whites or Hispanics." Bowe further points out that of working age blacks, just over 14% are disabled while the disability rates for Hispanic and white adult disabled are similar at 8.9%. At the same time, a review of census and NYS/OVR data, while utilizing the same parameters as used in the Bowe study, has demonstrated that there are significant differences in referral and closure trends for nonwhites and Caucasians.

While some 45% of the working aged disabled in need of services in New York are nonwhite, the percentage of nonwhite service providers within the NYS/OVR is less than one-tenth of one percent of the total number of VR counselors. To wit, New York State is faced with a significant gap in its ratio of nonwhite potential clients to nonwhite service providers. There is some evidence that private sector providers may have a slightly better ratio; however, the overall effect has been inadequate outreach to nonwhites and a consequent lower yield in successful vocational rehabilitation outcomes. In essence, the traditional vocational rehabilitation model falls short in responding to the needs of and enhancing rehabilitation of nonwhites for a number of reasons, among which are inadequate and/or inappropriate outreach, lack of involvement of nonwhites in the governance structure of the service delivery system, differences in value systems, a lack of awareness and sophistication on the part of nonwhites about accessing the system, and a lack of nonwhite advocacy groups (Simon, 1981).

PURPOSE

In order to address the questions of how minority disabled were accessing and faring in the vocational rehabilitation service delivery system, the NYS/OVR conducted a pilot study of a selected group of minority disabled persons. The central thrust of the study was focused on two key points in the vocational rehabilitation process, "entering" and "exiting" the vocational rehabilitation system.

The purposes of the study undertaken were:

—to establish baseline data for planning increased participation of nonwhites in the vocational rehabilitation program

—to explore reasons for closure in statuses 08, 26, 28, and 30 for nonwhites in New York State

—to explore how nonwhite disabled persons access and exit the vocational rehabilitation system in New York state
—to identify barriers to service delivery for nonwhite disabled clients, and
—to determine level of satisfaction with the service delivery system for nonwhites in NYS/OVR.

The study was comprised of two data samples. The first was drawn from a stratified random sample mail survey of former vocational rehabilitation clients and a second was drawn from the NYS/OVR data base management information system.

METHODOLOGY I

Sample:

During 1983 NYS/OVR participated in a (CSAVR) endorsed project involving an (RSA) awarded contract to Lawrence Johnson & Associates, Inc. (LJA) to "Evaluate the Delivery of Services to Select Disabled People by the Vocational Rehabilitation Service System."

As part of the research effort, LJA staff conducted site visits to eighteen state agencies for the purpose of interviewing State administrators/directors and selected counselors to obtain accurate information on each agency's service delivery system. A random sample of case records was reviewed on site (client confidentiality was maintained at all times).

A questionnaire was completed by NYS/OVR in order to provide a preliminary description of the agency system and clients served.

In addition, a client questionnaire was sent to a stratified randomly selected group of former OVR clients (client confidentiality maintained). The sample totalled 119 (white = 36, black = 32, Hispanic = 26, American Indian/Alaskan Native = 5, and Asian/Pacific Islanders = 20). Fifty-one percent of the sample consisted of status 26 closures, 24.4% were status 28 closures, and 20.5% were status 30 closures based on FFY 1982 agency data. These percentages were represented in each of the desired racial/ethnic mixes of the client population. Some respondent characteristics are as follows:

Handicaps indicated by respondents were identified in the following percentages:

4.3% Amputation
4.3% Deaf
4.3% Hearing
4.3% Learning Disability
8.7% Mental Retardation-Severe
13.0% Cardiac/Respiratory
13.0% Emotional
17.4% Mental Retardation-Mod/Mild
30.4% Orthopedic

The group which actually completed and returned the client questionnaire in New York State was:

6.9% American Indian/Alaskan
10.3% Asian/Pacific Islands
24.2% Hispanic
27.6% Black
31.0% White
34.5% Female
65.5% Male

Data Collection

NYS/OVR staff processed the surveys and forwarded them to LJA for analysis (grouped by size of vocational rehabilitation agency not by state) and at the same time initiated its own analysis of the data retrieved. Of the N = 119, 50 (42%) were returned and 69 (58%) were not returned. Of the 50 returned, 20 (58%) were completed and 21 (42%) were not deliverable. Most of the "undeliverables" occured because clients moved and had left no forwarding address.

Data Analysis

In-house analysis of the questionnaires was completed using the Human Service Dynamics Statsplus software and the Apple II+/E. The State Education Department's Burroughs mainframe computer was used to access data pertaining to competitive placement rates and wages of minority and majority rehabilitated clients. Since the latter run was recently reported for FY 1983, the results are presented under Methodology II.

The client questionnaire contained 24 questions which directly related to client characteristics and client satisfaction with the vocational rehabilitation service delivery system. Frequencies, crosstabs, chi-square, correlation, multiple correlation, and regression methods were applied to the data.

Results

Unfortunately, due to the extremely small sample involved in the survey data, significant findings were scarce. In many instances, however, it was apparent that if a larger sample were tapped, relationships and trends

would be more apparent. The data indicate client overall satisfaction with VR and the counseling received. Also, almost all respondents indicated that they would recommend VR to others. There was no apparent relationship between client race/ethnicity and satisfaction with VR counselors.

The following are key highlights which were gleaned from client responses to the questionnaire:

1. For both white and nonwhite the most frequent source of referral to NYS/OVR was from public service agencies, according to client responses.
2. White and nonwhite groups did not differ significantly regarding need for services which were not received.
3. There was very high correlation between rating of counseling received and overall satisfaction with vocational rehabilitation agency, regardless of client ethnic group. Those who completed training rated counseling positively, regardless of ethnicity.
4. Most respondents who completed the questionnaire item on "satisfaction with the provision of services that made it possible to find a job" rated the service as good.
5. Those with less than high school completion were more likely to be unemployed now. Most respondents had completed the 12th grade before starting VR services. The exception was Hispanics, who had completed grades 9-11. More whites than nonwhites had completed high school prior to starting vocational rehabilitation services.
6. Most clients rated their counselor's understanding of the client's problems in finding a job as very good to fair. Hispanics had more reponses in the poor to very poor range than any other group. Blacks never rated counselors below fair and usually rated counselors as very good.
7. Most whites and blacks did not indicate a need for services that they did not receive. Most Hispanics and American Indians indicated the need for services which they did not receive.
8. Specific services needed that were not provided, and which were suggested for how vocational rehabilitation could improve services, were training services. Counseling, medical, and placement services were mentioned less frequently than training as a perceived need by some clients.

Since the actual sample which completed the questionnaire was small, N=29, care must be taken not to view these findings as anything more than tentative and preliminary. If the sample were scaled up tenfold by chi-square analysis, statistical significance could be approached. Completion of the data analysis for the national study by Johnson & Associates, Inc., should provide a far more adequate basis for decision-making for improvement of the vocational rehabilitation service delivery system for select persons with disabilities.

METHODOLOGY II

Data Base Methodology

OVR has had to do "more with less" resources during the past several years. Funding for NYS/OVR has only increased by 20% between 1978 and 1982 during a period of 48% increase in cost of living, based on CPI (U.S. city average all urban consumers, U.S.A. all items). According to the NYS/OVR Annual Activity Report, rehabilitations in New York State have increased 12% for 1976-1983, and closures are down for the following: without service, 38%; not rehabilitated, 25%; and closed from applicant, 18%. However, new referrals are down 58% and new applicants are down 36% for 1976-1983. Total clients served are down 28%.

Clearly, equity issues (i.e., reaching adequate numbers of the target population which was 491,000 in FY 1981) remain problematic due to resource (funding) constraints. The percentage of nonwhites served has increased. However, frequent reasons for closure such as "failure to cooperate" and "refused services" may need further study since there is no explanation for what these terms really mean for a given client or group of clients.

The analysis in this section was conducted by utilizing NYS/OVR's data base. Notably missing from this data analysis is the Hispanic population of NYS/OVR's client cohort. This is due to the fact that the data entered for the Hispanic ethnic group is flawed. Presently, efforts are underway to pinpoint the problem so that these data will be available for analysis in the future.

Instrumentation

In-house Management Information System (MIS) records, annual reports, and special computer "runs" were examined in order to glean information pertaining to access to and egress from the NYS/OVR service delivery system by various ethnic groups. This effort focused on various entry and exit status reports for FY 1981 - FY 1983.

Data Collection

Most of the data are collected routinely by MIS from OVR District Offices. The data were organized and formatted by Bureau of Management Information (BMI) staff and by Bureau of Research and Innovation (BRI) staff. Client confidentiality was maintained at all times.

Data Analysis

Data were analyzed by BRI and BMI staff. Frequencies and percentages were used for this preliminary report. In the future, more extensive use of crosstabs and more powerful statistical procedures such as SPSS will enhance program evaluation capabilities.

Results

The following findings highlight entrance and exit trends for NYS/OVR clients between FY 1982 and FY 1983. Using OVR's data base, frequencies and percentages were calculated to determine "entering" and "exiting" patterns for nonwhite and white VR clients. Tables displaying these data follow the summary section of this report.

1. Placement rates for 26 closures for white clients increased by 2% while those for nonwhites decreased by 18%.
2. Rehabilitation rates for white clients increased by 4% while those for nonwhites decreased 4.5%.
3. Competitive placement rates for whites increased by a half of a percent while those for nonwhites increased by 2.5%.
4. When we looked at placed clients earning at or above minimum wage, we found that white placement rates declined 1.5% while such placements for nonwhites increased 11%.
5. The primary referral source across ethnic groups for 1982 and 1983 was individual or "self" referral.
6. The five most frequent sources of referral for all clients were 1) self, 2) health organizations and agencies, 3) educational institutions, 4) hospitals, and 5) social security and public sources. This order represented the rank order of referral sources for whites in both 1982 and 1983.
7. The most often cited reason for closure for the majority of white clients in fiscal years 1982 and 1983 was "refused services" (see Tables 6 and 7).
8. For nonwhites the top five referral sources shifted in order between 1982 and 1983 (see Table 8). The most frequently cited reason for closure for black clients was "failure to cooperate" (see Tables 6 and 7).
9. There was a higher tendency for the cases of white clients to be closed "rehabilitated" at or above minimum wage and for nonwhites to be closed non-rehabilitated.

DISCUSSION

This preliminary effort to assess the nature of nonwhite access to services and service outcomes has highlighted the need for further exploration of a number of parameters of the service delivery system in addition to the need to organize appropriate and accessible data bases in NYS/OVR so that equity and efficiency of vocational rehabilitation service delivery can be monitored in an ongoing fashion in order to meet the needs of nonwhite disabled clients.

Referral Sources

"Self referral" was the primary access route for *all* ethnic groups. However, the hierarchy of referral sources for whites remained unchanged in 1982 and 1983, while the hierarchy for nonwhite clients showed significant changes. This suggests that the traditional VR model is stable for white clients, but nonwhite clients may increase access to the VR system by emphasizing different referral sources.

Health organizations/agencies remained the second most common referral source for whites, and remained the least common referral source for nonwhites. Since utilization of health organizations/agencies would likely presume consistent because of gainful employment and geographic location in

white communities, such organizations do not produce many referrals of nonwhites. In addition, where these agencies are geographically located in nonwhite neighborhoods, the low number of referrals may suggest a lack of awareness of the potential benefits to clients offered by the VR system.

Social security/public sources moved in the hierarchy from fourth in 1982 to third in 1983 for nonwhite clients, while remaining the least frequent source for white clients. The actual disparity between whites and nonwhites in referrals from this source may reflect a greater awareness among white clients of the disincentives to participation in vocational rehabilitation vis-a-vis social security benefits.

An increase in the number of referrals from educational institutions raised this source to second place in the hierarchy for nonwhite clients. The factors which caused this increase may include the VR Jobs Training Partnership Act (JTPA) program and the strengthened connection between NYS/OVR and the Board of Cooperative Educational Services (BOCES) system.

CASE CLOSURE

There were two significant, possibly related, findings regarding case closure:

1. On the basis of Table 5, whites show a higher trend towards "closed rehabilitated," "closed in competitive employment," and "competitive employment at or above minimum wage" while nonwhites showed an elevated level of not-rehabilitated closures compared to rehabilitated or "successful" closures.
2. Among "unsuccessful" closures (Statuses 08, 28 and 30) for whites during 1982 and 1983 across all three states, the most common reason was "refused services," while for nonwhites the most common reasons were "failure to cooperate" and "unable to locate."

The possible connection between the above two findings is illustrated by the Asian/Pacific Islander ethnic group which experienced a drop in rehabilitation rate of 7.6% between 1982 and 1983. "Failure to cooperate," "handicap too severe," and "unable to locate" are commonly cited as reasons for the not-rehabilitated closures. One might suspect that these reasons for closure portend larger problems of communication due to linguistic barriers and cultural isolation characteristic of this population. It has been noted that the language barrier is reinforced through the closed society in which many Asian/Pacific Islanders function. The closed society hinders acculturation, economic advantage, and understanding of the vocational rehabilitation service delivery system. It fosters under-utilization of social service programs. As can be seen from Tables 1-4, while the placement rate, rehabilitation rate, and competitive placement rate were down for Asian/ Pacific Islanders, there was a sizable net gain (+11.3) for those Asian/Pacific Islanders who were competitively placed earning at or above the minimum wage. Though we suspect a relationship between educational level, cultural motivation, and job placement, the data collected did not lend itself to an explanation of this phenomenon.

Black Americans served by NYS/OVR exhibited a pattern of slight gain in placement rate (+.5%), rehabilitation rate (+3.2%), and competitive placement at or above minimum wage (+1.7%); however, they showed a net decline in competitive placement rate of (−1.4%). Consequently, while blacks gained in the number earning at least a minimum wage, their overall number of competitive placements declined slightly from 1982 to 1983, a factor which mirrors the decline of job placement for blacks generally. As the most frequent reason for black American Statuses 08, 28 and 30 closures cited in fiscal year 1983 was "failure to cooperate," "unable to locate," and "refused services" for these same statuses respectively in 1982, further analysis of case folders is necessary to determine the import of this shift which may or may not be related to psychological barriers. It seems, at least on the surface, to be contradictory to the fact that educational institutions ascended to second place as a referral source for black Americans in 1983 as one would anticipate those coming from educational institutions to have a greater awareness of the vocational rehabilitation process. At the same time, one must be cognizant of the fact that while education as a referral source for black Americans has moved up in the hierarchy of the top five referral sources in NYS/OVR for black Americans, social security and public service agencies along with concomitant disincentives moved upward in the hierar-

chy from fourth to third place. Thus, the relative gains which might have accrued from the upward movement of education as a referral source might have been offset by those for whom disincentives were great. A closer look in this area is certainly warranted.

The data showed a decline (−11.8%) in placement rates for American Indians and Alaskan Natives who finished services from 1982 to 1983, a maintenance of rehabilitation rates for Status 26 closures for this group, and an increase (+6.8%) in competitive placement rates; yet, this group experienced no relative gain in the percentage of clients competitively placed earning at or above the minimum wage, although there is sufficient data to suggest that college-educated Native Americans have little difficulty securing employment. The latter is reflective perhaps of the status of American Indian and Alaskan Natives in the general socio-economic structure. Native Americans have been isolated from the health and human service delivery system because of linguistic, educational, geographic, economic, and cultural barriers. In addition, there is general mistrust of the majority culture coupled with severe economic poverty due to high unemployment and limited opportunity for employment. Perhaps inherent in the lack of gain in competitive placement at or above the minimum wage for this ethnic group is the fact that the percentage of this population who finished services declined by 11.8% between 1982 and 1983. The increase in Status 26 closures for this group might reflect placements at less than minimum wage.

Despite the areas where the vocational rehabilitation service delivery system might have gaps in providing services to nonwhites, the data from former client surveys reveal an overall positive evaluation of the service delivery system, with a significant correlation between the evaluation of the counselor regardless of client ethnicity and the evaluation of the agency. Those who rated counselors high also rated the agency or service delivery system high with both receiving a higher preponderance of positive ratings.

SUMMARY

A pilot effort was directed at the analysis of two key points of the vocational rehabilitation service delivery system—"entering and exiting"—for a select group of white and nonwhite clients. The data analyzed revealed a number of areas in need of further study, namely: 1) Are referral source shifts noted in the pilot legitimate and what is the potential real impact of these changes for service delivery to nonwhites? 2) Does "failure to cooperate" as a reason for closure as used by counselors represent an ethnic bias or a legitimate reason for closure since "refused services" was the primary reason for closure for majority clients across statuses and across fiscal years while "failure to cooperate" was the predominant primary reason for closure for nonwhites, and 3) What accounts for the declines in placement rates for nonwhites, particularly where training has been completed?

Socio-cultural barriers notwithstanding, this preliminary or pilot effort has revealed the necessity for continuing to organize appropriate, accessible and manipulable data bases in NYS/OVR so that the equity and efficiency of the vocational rehabilitation service delivery system in New York can be monitored and its service delivery methods tailored to meet the needs of the pluralistic society to be served.

TABLE I

REHABILITATION OUTCOMES

PLACEMENT RATES (26/26 + 28) FOR MINORITY AND MAJORITY CLIENTS WHO FINISHED SERVICES

RACE	FFY 1982	FFY 1983	NET
Majority/White	71.4%	73.6%	+ 2.2%
Minority:			
Black (not Hispanic)	60.5%	61.1%	+ .5%
American Indian/ Alaskan Native	70.4%	58.6%	−11.8%
Asian/Pacific Islander	68.4%	61.3%	− 7.1%
Hispanic	(N/A)	(N/A)	(N/A)

TABLE II

REHABILITATION OUTCOMES

REHABILITATION RATES (STATUS 26) (26/26 + 28 + 30) FOR MINORITY AND MAJORITY CLIENTS

RACE	FFY 1982	FFY 1983	NET
Majority/White	57.7%	62.1%	+4.4%
Minority:			
Black (not Hispanic)	44.7%	47.9%	+3.2%
American Indian/ Alaskan Native	61.3%	61.3%	
Asian/Pacific Islander	55.9%	48.6%	−7.3%
Hispanic	(N/A)	(N/A)	(N/A)

TABLE III

REHABILITATION OUTCOMES

COMPETITIVE PLACEMENT RATES (STATUS 26 CLOSURES) FOR MINORITY AND MAJORITY CLIENTS

RACE	FFY 1982	FFY 1983	NET
Majority/White	50.9%	51.5%	+ .6%
Minority:			
Black (not Hispanic)	49.9%	48.5%	−1.4%
American Indian/ Alaskan Native	57.9%	64.7%	+6.8%
Asian/Pacific Islander	50.0%	47.1%	−2.9%
Hispanic	(N/A)	(N/A)	(N/A)

TABLE IV

REHABILITATION OUTCOMES

PERCENTAGE OF MINORITY AND MAJORITY CLIENTS COMPETITIVELY PLACED EARNING AT OR ABOVE THE MINIMUM WAGE

RACE	FFY 1982	FFY 1983	NET
Majority/White	71.4%	69.8%	– 1.6%
Minority:			
Black (not Hispanic)	66.4%	68.1%	+ 1.7%
American Indian/ Alaskan Native	63.6%	63.6%	
Asian/Pacific Islander	73.1%	84.4%	+11.3%
Hispanic	(N/A)	(N/A)	(N/A)

TABLE V

CHARACTERISTICS OF TOTAL (26, 28, 30's) CLIENTS SERVED IN FFY '83

Status 26's consisted of:	81.8%	Majority/White
	17.3%	Black (not Hispanic)
	.2%	American Indian/Alaskan Native
	.7%	Asian/Pacific Islander
	(N/A)	Hispanic
Status 28's consisted of:	71.7%	Majority/White
	26.9%	Black (not Hispanic)
	.3%	American Indian/Alaskan Native
	1.1%	Asian/Pacific Islander
	(N/A)	Hispanic
Clients closed in status 30 included:	71.8%	Majority/White
	27.1%	Black (not Hispanic)
	.1%	American Indian/Alaskan Native
	1.1%	Asian/Pacifica Islander
	(N/A)	Hispanic

For FFY '83 - Total of those closed in competitive employment were as follows:

82.8%	White
16.4%	Black (not Hispanic)
.2%	American Indian/Alaskan Native
.6%	Asian/Pacific Islander
TOTAL	100.0%

Total of those clients competitively placed earning at or above minimum wage (Earning greater than $133 for FFY '83):

82.9%	White
.2%	American Indian/Alaskan Native
16.1%	Black (not Hispanic)
.8%	Asian/Pacific Islander
TOTAL	100.0%

TABLE VI - REASON FOR CLOSURE FFY 1982

Ranked (highest to lowest) reason for closure by ethnic group and closure status displaying five most frequent reasons for NYS/OVR clients:

ETHNIC GROUP	STATUS 08	STATUS 28	STATUS 30
White	Refused services	Refused services	Refused services
	Failure to cooperate	Unable to locate	Failure to cooperate
	Handicap too severe	Failure to cooperate	Unable to locate
	Other	Handicap too severe	Handicap too severe
	Unable to locate	Other	Other
Black (not Hispanic)	Failure to cooperate	Unable to locate	Refused services
	Refused services	Failure to cooperate	Failure to cooperate
	Handicap too severe	Refused services	Unable to locate
	Unable to locate	Handicap too severe	Handicap too severe
	Other	Other	Other
Indian/Alaskan	Failure to cooperate	Failure to cooperate	Unable to locate
	Refused services	Handicap too severe	Handicap too severe
	Unable to locate	Other	Refused services
	Other	Refused services	Death
	Handicap too severe/ Institutionalized (tied for fifth place)	N/A	N/A
Asian/Pacific Islander	Refused services	Unable to locate	Refused services
	Unable to locate	Handicap too severe	Failure to cooperate
	Handicap too severe	Failure to cooperate	Handicap too severe
	Failure to cooperate	Refused services	Unable to locate
	Other	Other	Other

TABLE VII - REASON FOR CLOSURE FFY 1983

Ranked (highest to lowest) reason for closure by ethnic group and closure status displaying five most frequent reasons for NYS/OVR clients:

ETHNIC GROUP	STATUS 08	STATUS 28	STATUS 30
White	Refused services	Refused services	Refused services
	Failure to cooperate	Unable to locate	Failure to cooperate
	Other	Failure to cooperate	Unable to locate
	Handicap too severe	Handicap too severe	Handicap too severe
	Unable to locate	Other	Other
Black	Failure to cooperate	Failure to cooperate	Failure to cooperate
	Refused services	Unable to locate	Refused services
	Unable to locate	Refused services	Unable to locate
	Handicap too severe	Handicap too severe	Handicap too severe
	Other	Other	Other
Indian/Alaskan	Refused services	Refused services	Failure to cooperate
	Failure to cooperate	Failure to cooperate	N/A
	Other	Unable to locate	N/A
	Handicap too severe	Handicap too severe	N/A
	No vocational handicap	Other	N/A
Asian/Pacific Islander	Failure to cooperate	Unable to locate	Refused services
	Refused services	Handicap too severe	Handicap too severe
	Unable to locate	Failure to cooperate	Other
	Handicap too severe	Refused services	Unable to locate
	Other	Death; Institutionalized Other (three way tie)	Failure to cooperate

TABLE VIII

Referral sources for NYS/OVR clients by ethnic groups for FFY 1982 and FFY 1983 - five most frequent referral sources ranked (highest to lowest) for each ethnic group:

ETHNIC GROUP	FFY 1982 REFERRAL SOURCE	FFY 1983 REFERRAL SOURCE
White	Self	Self
	Health Organizations and Agencies	Health Organizations and Agencies
	Educational	Educational
	Hospitals	Hospitals
	Social Security and Public sources	Social Security and Public sources
Black	Self	Self
	Hospitals	Educational
	Educational	Social Security and Public sources
	Social Security and Public sources	Hospitals
	Health Organizations and Agencies	Health Organizations and Agencies
Indian/Alaskan	Self	Self
	Social Security and Public sources	Educational
	Hospitals	Social Security and Public sources
	Educational	Hospitals
	Health Organizations and Agencies	Health Organizations and Agencies
Asian/Pacific Islander	Self	Self
	Hospitals	Educational
	Social Security and Public sources	Hospitals
	Educational	Social Security and Public sources
	Health Organizations and Agencies	Health Organizations and Agencies

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8 • Some Observations on Blacks and Physical Disability

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Abstract

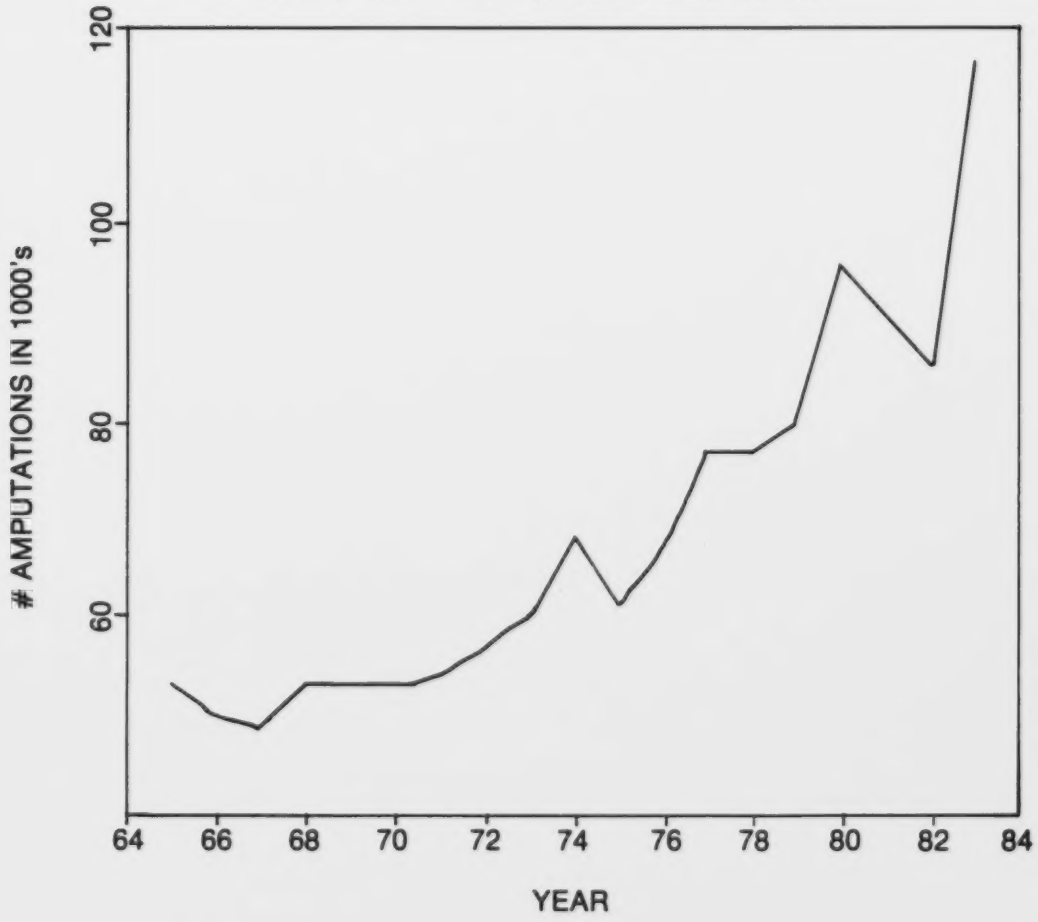
This article reviews the available data on physical disability among blacks, who have a higher prevalence than any other racial group in the United States. The authors discuss lower extremity amputation as an example of a physical impairment particularly more common among blacks and which can cause severe disability. They conclude by stressing the great need for more information concerning disabling physical impairment and the urgent need for extensive and effective preventive measures.

According to reliable sources (Bowe, 1982; DeJong and Lifchez, 1983) the prevalence of physical disability among blacks is higher than among any other group in America. This is true for both sexes and across all age groups. The picture is particularly distressing for the "working age" population defined as persons 18–64 years of age. DeJong (1983) quoting his source, the 1976 Survey of Income and Education, reported 19.4% of this segment of the black population in its most productive years had a chronic health condition preventing participation in a major activity appropriate to their age. The comparable figure for the white population was 12.6%, while that for Hispanic persons was 10.6%. We know of no convincing evidence to suggest that this picture has significantly improved during the intervening years. Rather, we have concern that the increasing level of poverty since that study is being accompanied by the usual concomitants of poverty, including more disability.

National data on the prevalence of specific major physical impairments such as stroke, other cardiovascular disorders, head injuries, spinal cord injuries, and amputations according to race are limited. The available evidence, however, suggests similar patterns (Most and Sinnock, 1983; Moss, 1981; Young et al, 1982). A variety of factors likely contributes to the high prevalence of physical impairment and associated disability among blacks. These include such socioeconomic factors as low income and limited education. Health related factors include high rates of premature births, hypertension, diabetes, and physical trauma. This article further explores this scenario through the example of the lower extremity amputee.

Illustrative of this public health problem is the lower extremity amputee—an example of serious physical impairment with associated disability. The major causes of lower extremity amputations are: atherosclerosis with or without diabetes and trauma. Malignant tumors and various forms of congenital abnormalities account for another small percentage. Recent reports indicate that the lower extremity amputee population has shown important changes over recent decades. According to the National Center on Health Statistics, data from the National Hospital Discharge Survey indicate that the size (Figure 1) of that population is increasing (1980). Other information suggests that the major cause—atherosclerosis—has shown an increased percentage among the various causes of amputation (Kay and Newman, 1975). A likely contributing reason for

FIGURE 1
Incidence of Lower Extremity Amputation by Year U.S.



Source: NCHS
Graph prepared by R. Prince

60

both changes is the increasing size of the elderly population.

As regards rehabilitative potential, the majority of patients who experience a major lower extremity amputation can successfully use an artificial limb, either with or without a walking device. Most become independently functional at many of their usual activities. Important determinants of rehabilitation success—particularly vocational adjustment—include physiologic age, type of previous employment, and how crucial the leg was to performance at the specific job. An example can be helpful. Two persons, both of whom may have experienced the same level of amputation, could have entirely different levels of vocational disability. A judge or teacher might experience little or no change in vocational ability to function. On the other hand, a farmer or messenger could have substantial vocational disability from the same anatomic impairment. Note also the implicit impact of educational achievement on level of disability and the importance of individualizing each rehabilitation assessment and plan.

Also, functional levels are influenced by the level of the amputation. Walking ability is substantially higher if the amputation is below the knee than if the leg is removed above the knee. This factor gains even greater significance when we realize that a number of the atherosclerotic patients eventually lose the other leg. Whereas, most bilateral below-knee amputees can walk with artificial limbs, it is rare for a bilateral above-knee amputee to accomplish this.

All available data suggest that the incidence of lower extremity amputation is higher among blacks than other racial groups. Workers from the Center for Disease Control (Most and Sinnock, 1983) have reported available data on rates of lower extremity amputations among diabetics, a particularly prone group. In New Jersey (1979) the rates were 95.5 per 10,000 diabetics for blacks and 62.2 for whites. The South Carolina (1973) rates were 94.4 for blacks and 41.6 for whites. Why is this so? Part of the reason is that many of the several factors contributing to the various causes of loss of limb are higher in blacks.

The factors responsible for the most common cause of this impairment—atherosclerosis—are in large part the same factors responsible for other serious impairments caused by disorders of the circulatory system, more specifically, progressive or sudden blockage of the arteries which supply oxygen to the heart, brain, and kidneys. The underlying disease, a form of arteriosclerosis known as atherosclerosis, is frequently referred to as the scourge of the Western society. This disease moves insidiously, sometimes explosively, causing heart attacks, strokes, kidney failure and gangrene necessitating amputation. Some of the factors contributing to the development and progression of this devastating process include: hypertension, cigarette smoking, diabetes, and diet high in animal fat.

The prevalence of many of these factors is substantially higher among blacks than whites. With the additional socio-economic factors of limited income, lower levels of educational achievement, and poor housing, the scenario becomes aggravated, causing an increase in the incidence of impairments and the degree of associated disability caused by these conditions. A similar picture of contributing factors, incidence and prevalence of physical impairments, and levels of disability can probably be constructed for most disabling conditions in blacks. They collectively underlie the devastating effect upon one-fifth of the black population in its most productive years—disabled.

This situation which has received almost no public and minimal professional attention represents a national disgrace for the most affluent country in the world. We as workers with the handicapped must take up the challenge posed by this dismal picture. We must intensify our efforts as advocates for those who are physically handicapped while we reinforce our various methodologies and develop innovative approaches to the improvement of function and prevention of disability.

Further, additional information must be developed to more precisely define the extent of the underlying disorders causing physical disability, determine the relative incidence and prevalence among the spectrum of physical impairments, and more carefully assess the impact upon human function due to these conditions. Such information can form a sound basis for the development of rational, effective strategies to turn this waste of human potential into a vast source of human achievement.

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9 • Sociocultural Aspects of Disability and Rehabilitation

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Abstract

This paper is a review of some of the interests and initiatives in rehabilitation that will foster a better understanding of social and cultural factors. It also examines the accessibility of ethnic minorities to rehabilitation and the benefits they received. Some factors of cross cultural relationships are listed, and the paper offers some implications to improve rehabilitation services for minority populations with handicapping conditions. The author provides Hall's (1973) "Map of Culture"—a teaching device portraying the influence of culture. There is also a comparison of cultural differences between ethnic minority groups and the white middle class in specific areas. Wilson concludes by suggesting some guidelines for the Howard University Project: need to emphasize cultural factors, need for non-racist practitioners and cross cultural training, need for determining the viability of alternate systems, need for research and dissemination of findings, and need for a synergistic and transcendent model.

REHABILITATION'S INTEREST IN SOCIAL AND CULTURAL FACTORS

Nearly twenty years ago, Mary E. Switzer (1965), the late Commissioner of the U.S. Vocational Rehabilitation Administration, challenged rehabilitationists to become more

sensitive to and effective with new clients in the rehabilitation system:

> . . . we face our greatest problems in the subtle things so essential to the rehabilitation process. In selecting disabled people for rehabilitation we could pick and choose 15 years ago. Today our state agencies are seeing people whom we really cannot communicate with at all. Sometimes we might as well be speaking Chinese as trying to reach disabled young Negroes in slum housing in our big cities, people who have been on relief for three generations. Too often we do not know how to talk to these people or how to make any real contact with them, and it takes a very dedicated and unusual type of professional individual who can emerge from a middle-class upbringing to really be effective in this kind of milieu. We need to know why this is and how we can overcome it—what can we do both short-range and long-range, if our society is to survive. (p. xi)

Indeed, during the 1960s and early 1970s, there was a great deal of activity aimed at examining the effects of racial differences and poverty on access to and development of persons through rehabilitation. Psychologists (Neff, 1971), sociologists (Sussman, 1965), and anthropologists (Chapple, 1970), with encouragement and funding assistance from the Vocational Rehabilitation Administration, began to study and provide insights on cultural differences. Rehabilitation counselor educators (Ayers, 1968; Dunn, 1967; Feinberg & Cohen, 1969; Kunce & Cope, 1969; Peterson, 1967; and Wilson, 1970) also examined, spoke on, and wrote about the effects of cultural differences on the rehabilitation process.

Also in the early 1970s, the National Rehabilitation Association, using experts and representatives from the following groups, published its Ethnic Differences Series: American Indians (Mackey & Blanchard, 1972); Black Americans (Edward, 1972); Mexican-Americans (Guerra, 1972); and Puerto Ricans (Hidalgo, 1972).

Throughout the years, there have been many conferences, some associated with the aforementioned efforts, to generate sensitivity to and understanding of ethnic minorities and their problematic relationships with the rehabilitation system and to solve the need for minority manpower in the professional and support work force (Ayers, 1974; Johnson & Wen, 1980). In addition, efforts have been made through demonstration projects to facilitate the access of minorities to the system and to meet their needs through modifications in the delivery system (Spencer, 1967; Virginia Department of Vocational Rehabilitation, 1973).

We are reminded that we still face problems in extending to ethnic minorities and culturally different persons the benefits of the rehabilitation system. The seminal study of Atkins and Wright (1983) concluded that unequal treatment of blacks was evident in all dimensions of the public rehabilitation process and that blacks entered and exited these programs in a disproportionately more disadvantaged status than whites. Other recent studies include the examination of severely disabled minorities in inner cities and the rehabilitation process (Royall and Corthell, 1981), the national study of the evaluation of vocational rehabilitation services to various racial and ethnic minorities by Lawrence Johnson and Associates (1981), and the current Howard University Model to Improve Rehabilitation Services for Minority Populations with Handicapping Conditions.

Even though these interests and initiatives were stimulated by and were concurrent with civil rights initiatives which led to the Civil Rights Act of 1964 and the civil rights legislation and regulations for the handicapped (Federal Register, 1977), minorities continue to be viewed as less than ideal clients for the system as it is organized, budgeted, staffed, directed, and evaluated. They experience problems in accessing and in receiving the developmental benefits available from participation in the system.

When educational and other institutions fail in the delivery of services to minorities, according to Hollins (1982, p. 41), five ideological reasons are offered as explanations:

(1) the deprivation thesis: blaming the client;
(2) the institutional racism thesis: blaming the professionals;
(3) the cultural conflict thesis: blaming ethnic cultural differences;
(4) the caste structure thesis: blaming social structure of society; and
(5) the class conflict thesis: blaming the capitalist economic system.

While each of these theses has some elements of validity, and proponents for these theses propose specific solutions to service access and delivery problems, e.g., new modes of service delivery to reduce the effects of racism and cultural conflict (Gellman, 1966; Solomon, 1976), the problem continues to exist and the rehabilitation services for ethnic minorities lag behind the access and benefits gained by white Americans.

SOME SOCIOCULTURAL INFLUENCES ON DISABILITY AND REHABILITATION

Rehabilitation can be viewed as a social system with rational purposes and procedures for converting disability into ability through rules, roles, and relationships within a cultural context (Chapple, 1970; Sussman, 1965). These rules, roles, and relationships may favor some clients over others, and it appears that middle-class white persons are favored over poor whites and ethnic minorities or culturally different persons.

But what are the cultural and sociocultural influences? For a good background for understanding cultural and sociocultural influences, I suggest the following books for study: *The Silent Language* by Hall (1973) and *Communicating with Strangers* by Gudykunst and Kim (1984).

An excellent orientation may also be gained from reading a chapter in a recent book on community health nursing that is titled "Social and Cultural Influences on Health Care" and authored by Bauwens and Anderson (1984). The concepts presented are as relevant to disability as to illness and to rehabilitation as to health care. A sampling of some of the content is illustrative:

> Culture enables us to interpret our surroundings and the actions of people around us and to behave in ways that make sense. "Culture consists of standards for deciding what is, what can be, how one feels about it, and how to go about doing it" . . . Some anthropologists conceive of culture as a set of rules. Each culture provides the individual with a set of rules for behaving and for interpreting the behavior of others. The set of rules can be compared to a cultural grammar—"culture is to behavior" as "language is to speech" (pp. 239-240).

> Culture influences our expectations and perceptions of symptoms; the way we label sickness; when, how, and to whom we communicate our health problems; and how long we remain under care. Because health and illness are shaped by cultural factors, there is variation in health care behavior, health status, and patterns of sickness and care within and between different cultures . . . (p. 244).

> If the health care provider and the client share the same beliefs and values, agree on appropriate treatment, and anticipate the same outcome, the client can be expected to comply with the provider's proposed health care. To the extent that the provider and client differ, the client's behavior can be expected to differ from what the provider desires, although the ways in which it may diverge cannot always be predicted (p. 244).

> People who have been reared in a group with common origins and a sense of identity often share basic concepts and attitudes toward health and illness as well as styles of behavior and concerns about the world. The effects of enculturation influence health-seeking behaviors and activities to prevent and treat disease. Nevertheless, there is individual variation, and appreciation of this helps to prevent the common tendency of health professionals and others to stereotype ethnic group members, which can be dangerous. If health workers are conversant only in bits of isolated aspects of health beliefs and behaviors, holism is lost and intracultural variation obscured. An accurate description of the culture and behavior of ethnic group members ideally provides an assessment of the range of behavior and the commonly held cultural beliefs and values. Without this knowledge, health professionals find themselves confronted with what appears to them to be strange and curious notions, and they feel the need to overgeneralize (pp. 244, 246).

It is important to understand that culture is pervasive and influences all of our roles, relationships, and meanings. Hall (1973), in his "Map of Culture" (pp. 193-199) presented here as Figure 1, provides a teaching

FIGURE 1.
A Map of Culture*

Primary Message Systems	Interactional 0	Organizational 1	Economic 2	Sexual 3	Territorial 4	Temporal 5	Instructional 6	Recreational 7	Protective 8	Exploitational 9
Interaction 0	Communication Vocal qualifiers Kinesics Language 00	Status and Role 01	Exchange 02	How the sexes interact 03	Places of interaction 04	Times of interaction 05	Teaching and learning 06	Participation in the arts and sports (active and passive) 07	Protecting and being protected 08	Use of telephones, signals, writing, etc. 09
Association 1	Community 10	Society Class Caste Government 11	Economic roles 12	Sexual roles 13	Local group roles 14	Age group roles 15	Teachers and learners 16	Entertainers and athletes 17	Protectors (doctors, clergy, soldiers, police, etc.) 18	Use of group property 19
Subsistence 2	Ecological community 20	Occupational groupings 21	Work Formal work Maintenance Occupations 22	Sexual division of labor 23	Where the individual eats, cooks, etc. 24	When the individual eats, cooks, etc. 25	Learning from working 26	Pleasure from working 27	Care of health, protection of livelihood 28	Use of foods, resources, and equipment 29
Bisexuality 3	Sex community (clans, sibs) 30	Marriage groupings 31	Family 32	The Sexes Masc. vs. Fem. Sex (biological) Sex (technical) 33	Areas assigned to individuals by virtue of sex 34	Periods assigned to individuals by virtue of sex 35	Teaching and learning sex roles 36	Participation in recreation by sex 37	Protection of sex and fertility 38	Use of sex differentiating decoration and adornment 39
Territoriality 4	Community territory 40	Group territory 41	Economic areas 42	Men's and women's territories 43	Space Formal space Informal space Boundaries 44	Scheduling of space 45	Teaching and learning individual space assignments 46	Fun, playing games, etc., in terms of space 47	Privacy 48	Use of fences and markers 49
Temporality 5	Community cycles 50	Group cycles 51	Economic cycles 52	Men's and women's cyclical activities 53	Territorially determined cycles 54	Time Sequence Cycles Calendar 55	When the individual learns 56	When the individual plays 57	Rest, vacations, holidays 58	Use of time-telling devices, etc. 59
Learning 6	Community lore—what gets taught and learned 60	Learning groups—educational institutions 61	Reward for teaching and learning 62	What the sexes are taught 63	Places for learning 64	Scheduling of learning (group) 65	Enculturation Rearing Informal learning Education 66	Making learning fun 67	Learning self-defense and to stay healthy 68	Use of training aids 69
Play 7	Community play—the arts and sports 70	Play groups—teams and troupes 71	Professional sports and entertainment 72	Men's and women's play, fun, and games 73	Recreational areas 74	Play seasons 75	Instructional play 76	Recreation Fun Playing Games 77	Exercise 78	Use of recreational materials (playthings) 79
Defense 8	Community defenses—structured defense systems 80	Defense groups—armies, police, public health, organized religion 81	Economic patterns of defense 82	What the sexes defend (home, honor, etc.) 83	What places are defended 84	The When of defense 85	Scientific, religious, and military training 86	Mass exercises and military games 87	Protection Formal defenses Informal defenses Technical defenses 88	Use of materials for protection 89
Exploitation 9	Communication networks 90	Organizational networks (cities, building groups, etc.) 91	Food, resources, and industrial equipment 92	What men and women are concerned with and own 93	Property—what is enclosed, counted, and measured 94	What periods are measured and recorded 95	School buildings, training aids, etc. 96	Amusement and sporting goods and their industries 97	Fortifications, armaments, medical equipment, safety devices 98	Material Systems Contact w/ environment Motor habits Technology 99

*E. Hall (1973) *The silent language.*

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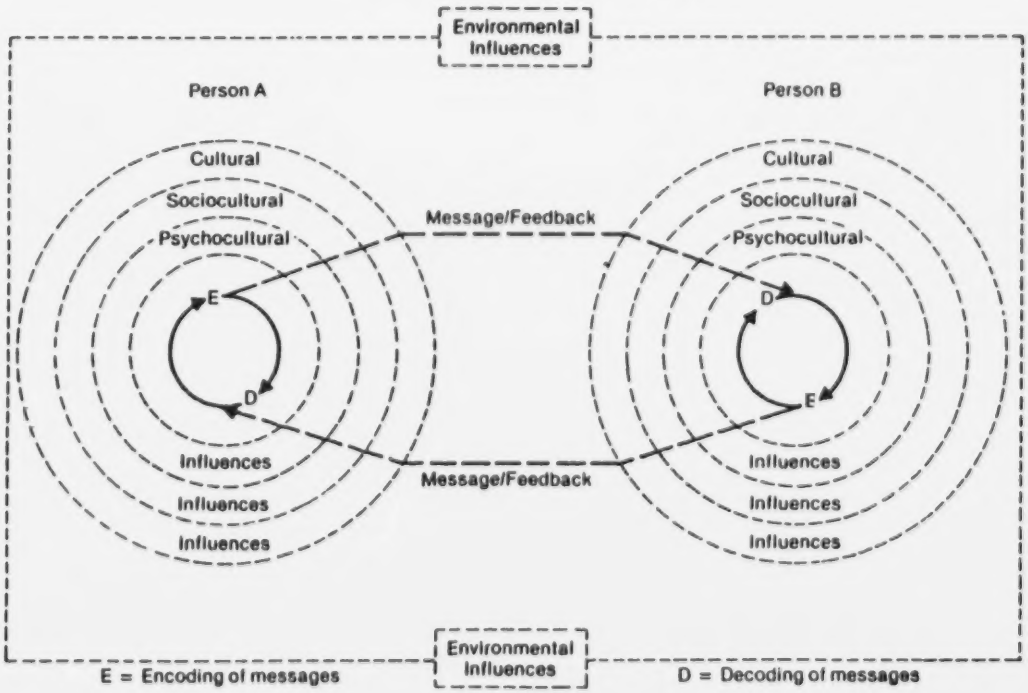
device for seeing the influence of culture on everything we do. The map enlightens us to the patterns, extensions, and results of interactions between the following 'Primary Message Systems' that give the dynamics and form of cultures: interaction, association, subsistence, bisexuality, territoriality, temporality, learning, play, defense, and exploitation. Except for the cells combining the interaction message system with the other message systems, the cells depict patterns, interactions, and extensions that are nonverbal, and this is why Hall refers to culture as "the silent language." According to Hall, culture is learned formally through precept and admonition, informally through modeling, and technically through oral and written instruction. Most meanings are learned early in life and are resistant to change.

While the map is limited by being two-dimensional, it orients us to the complexity and comprehensiveness of cultural patterns and rules, roles, and relationships related to those patterns. Indeed, think about how disabled minority persons fit into or are excluded from the patterns suggested in each cell. Think about what is needed to enable minority persons with disabilities to be viewed more favorably and to participate more meaningfully in American culture. While thinking in this manner may be difficult, it is essential if we are to understand how culture influences rehabilitation and the meaning of disability.

Figure 2 is a model of cross-cultural communication presented by Gudykunst and Kin (1984). The model indicates that a communicator is influenced by cultural influences or the cultural postulates, means, and ends held by the communicator; sociocultural influences such as group membership, role relationships, and interpersonal relationships; psychocultural influences such as cognitive processing patterns, including

FIGURE 2.
An Organizing Model for Studying
Communication with Strangers



stereotypes, prejudices, ethnocentrism, and attributions; and both physical and psychological environmental influences. The exchanges of meanings between communicators are affected by these factors or influences, and feedback on meanings needs to be exchanged and clarified for accurate understanding to occur.

Let us now examine how value differences can influence communication. Figure 3 summarizes some value differences between ethnic minority groups and the white middle class (suggested by Sanchez, 1964). These differences are modal differences in that they tend to be more characteristic than not of the groups. For the ethnic minority groups, the values tend to be related to their lower socioeconomic positions, have some origins in their privations, and conflict with persons who control access to the things they need and want.

Let us examine how different assumptions about interpersonal relationships, time, relationship to nature, activity, and human nature influence cross-cultural communications. More specifically, let us examine how different perceptions of self, locus of control, and the costs of cultural change can operate in cross-cultural relationships.

Perception of Self. In his examination of American cultural patterns, Stewart (1972), indicates that the majority of Americans are taught to view themselves as separate, independent persons who have their own wishes, interests, and ambitions. They are taught to

FIGURE 3.

Cultural Differences Between Ethnic Minority Groups and The White Middle Class

Value Orientation	White Middle Class	Ethnic Minorities
Interpersonal or Relational	Individualism (i.e., emphasis of the individual ahead of any group considerations; strongly competitive individually and in groups).	Strong lineality (i.e., the vertically structured group hierarchy is stressed) and collaterality orientation (i.e., the horizontally structured group, "one for all and all for one" aspect of group loyalty, and existence of the extended family). Group rather than individual goals are stressed.
Time	Future time orientation (i.e., anything new is clearly better than anything old, and hopes are usually cast for the time to come).	Present time orientation (i.e., stress on the present with little or no regard for the future or past and, therefore, with scarce planning ahead of time).
Relationship to Nature	Man over or control of nature (i.e., nature can be tamed to man's will and control of his fate resides within his own skill and resources).	A subjugated to nature orientation (i.e., the stress is on the helplessness and weakness of man, factors that must be realized to gain any control at all over fate).
Activity	Doing orientation (i.e., striving for competence and achievement as measured by outside standards are important factors on the road to success).	Being orientation (i.e., the isness of behavior, the spontaneous inclination to act in accordance with one's mood, feelings, desires, and impulses).
Human Nature	A human but perfectible human nature orientation.	A mixed good and evil conception of human nature (i.e., roughly the characteristic Judeo-Christian notion).

value self-reliance and they assume all other persons see themselves this way.

Persons in most ethnic minority subcultures, however, are more group-oriented, prize individualism to a lesser degree, and see themselves as inextricable parts of the ethnic minority group and their family.

Rehabilitationists, socialized along majority middle-class lines in their professional development and orientation to the rehabilitation system, generally experience extreme difficulty in comprehending the thought processes of persons who do not share their conception of the self as an individual unit but instead as integral parts of a web of relationships.

Because of this difference in perception of self, ethnic minority persons are likely to be viewed not only as different but as undesirably different, unmotivated, and/or not cooperative for rehabilitation.

Locus of Control. A related concept is that of locus of control. Most professional rehabilitationists embrace middleclass values and see themselves as responsible for their own situations in life and assume that any changes in what they do will arise, ultimately, from decisions they themselves make.

Americans from lower socioeconomic groups, of which most minority persons are a part, however, do not share this notion because of the experiences of their group in trying to control their own destiny. Instead, they have learned to assume that other persons, social or spiritual forces, or whatever, like "luck," determine what happens to them. In many, many instances, disability and its treatment is viewed as being dependent upon the will of God or other spirits, and religion is not separated from illness, disability, health, prognosis, treatment, and outcomes.

As Sue (1978) argues, the idea of making their own decisions about their own futures does not make sense to them. Given this orientation, rehabilitationists are likely to see ethnic minority persons with disabilities as poorly motivated and high risks for a system which embraces the value of internal locus of control and pragmatic rationality. Many of these persons, therefore, are viewed as being mentally limited and doomed to remain dependent on public welfare, relatives, or their extended family.

Costs of Cultural Change. In his analysis of the problems encountered by social agencies and the socially handicapped in connecting and working together to attain improved conditions and functioning for the handicapped, Bredemeir (1966) suggests that the costs of change may be viewed as too high by both.

While middle-class persons are likely to view change as being in their self-interest with significant benefits for their individualism, ethnic minority persons may view the costs of change differently in terms of their current and secure relationships. Change may also generate fear of disappointment, anger, or even abandonment from the family. Change may also generate problems in new relationships which may result in failure to cope effectively (e.g. losing a job). The benefits of the status quo are clear and immediate, while the benefits of change are vague, distant, and risky.

Because of differential perceptions in the costs of change, ethnic minorities, in trying to deal with cultural conflicts, may appear to be unmotivated and uncooperative. Unfortunately, rehabilitationists, at least in their writings, have not dealt effectively with ethnic minority conflicts regarding loss of friends, loss of status, and loss of "face" as these relate to the rehabilitation process.

The analysis of the cost of change by ethnic minorities may also be tied in with the meaning which agencies of change have to them. As pointed out by Solomon (1976), black clients, for example, may not have firm convictions that practitioners in the agencies to which they have been referred have skills they can use in solving their problems, that establishing rapport across racial lines is particularly difficult, and that "expertise in dealing with their problems in living can be found in established social or mental health agencies since these same agencies have been perceived as accepting and perpetuating the negative valuation of blacks that is endemic in society" (p. 340).

SOME EFFECTIVE CROSS-CULTURAL RELATIONSHIP FACTORS.

While the record of effective cross-cultural transactions and interactions in rehabilitation is spotty, the literature does suggest some knowledge, attitude, and activity factors or competencies that can improve

service delivery—casefinding, intake, assessment, services, and outcomes—for persons motivated by ethnic minority or cultural differences.

In the casefinding or outreach and intake areas, rehabilitationists need knowledge, attitude, and skill competencies to deal with the following problems presented by ethnic minority persons and described by Bredemeier (1966) and Pape, Walker, and Quinn (1983):

- skepticism and mistrust of public service delivery systems as a result of their group's experience with the delivery systems
- lack of interest in service delivery systems because the disability is viewed as a punishment which must be borne for sins committed by potential clients or their parents
- lack of knowledge about or familiarity with rehabilitation service delivery systems and valid proof of the benefits for ethnic minorities
- ambivalence, resistence, and fear of devaluation, cultural conflict, and the reinforcement of lowered self-worth

Beyond casefinding and intake, these problems interacting with earlier negative and devaluative educational and testing experiences may frustrate the cooperation of ethnic minority persons in the assessment and planning stages. And if goals are established and services to reach those goals are begun, ethnic minority clients may have unresolved fears and conflicts regarding the likelihood of upward mobility and the security of the benefits to be gained by rehabilitation change.

In their analysis, Pape, Walker, and Quinn (1983) provided examples of facilitative and nonfacilitative interactions and transactions of rehabilitationists with ethnic minority clients— in this case, Asian, Black, and Hispanic Americans. Their analysis encouraged me to identify some of the effective knowledge, attitude, and skill competencies exhibited by rehabilitationists in relating to clients with ethnic minority or cultural differences.

By relating effective knowledge, attitude, and skill factors of rehabilitationists gleaned from the literature cited in this paper to some of the cultural, sociocultural, psychocultural, environmental, and communication components presented by Gudykunst and Kim (1984), I generated Figure 4 which emphasizes the need for rehabilitationists who work with disabled persons from ethnic minority and culturally different backgrounds to acquire and exhibit "a knowledge and understanding of cultural diversity factors as these relate to accurate problem identification, rehabilitation planning, and service provision" (Pape, Walker, and Quinn, 1983, p. 18).

FIGURE 4.

Effective Knowledge, Attitude, And Skill Factors of Rehabilitationists in Relating to Ethnic Minorities And Their Cultures

RELATING TO CULTURAL VALUES AND BELIEFS

- Exhibits cultural sensitivity and exhibits skills in getting, understanding, and utilizing culture-specific information.
- Respects culturally familiar protocols and conceptions of what is acceptable and desirable.
- Understands the freedom and constraints placed on persons by their cultural norms and values.
- Understands the potential danger points for culturally different persons generated by cultural conflicts and exhibits skill in resolving conflicts as soon as they arise.
- Knows work and other developmental opportunities in the client's home community and exhibits skill in referring clients and monitoring the helpfulness of the resources.
- Understands the developmental and defensive effects of indifference, ignorance, and devaluative attitudes and behaviors of majority persons on minority persons because of cultural differences.

- Understands and is able to cope with the fact that some disabled persons may be perceived in their own communities as being unsound, incompetent, and cursed for an alleged sin committed by themselves or by their parents.
- Demonstrates competence in relating to and working with ethnic minority persons in a variety of situations.

RELATING TO SOCIOCULTURAL FACTORS,
(INDIVIDUAL VS. GROUP, PERSONALISM, AND HIERARCHY)

- Understands family commitments and hierarchy.
- Demonstrates skill in a family-oriented approach and has a positive orientation toward the inclusion of the extended family in the helping relationship.
- Is favorably oriented toward family education and cooperation.
- Exhibits skill in using the extended family system for effecting cooperation and resolving conflicts.
- Knows and is skilled in selecting community resources that have cultural sensitivity and can be helpful.
- Understands ethnic minority reluctance to focus on reviewing childhood history.
- Exhibits a genuine concern for the ethnic minority client as a human being with assets and potentials to be valued.
- Understands the role status of the client, the family, and group and understands the client's need to consult with significant others before making decisions.
- Is appropriately formal or informal and directive or non-directive.

RELATING TO PSYCHOCULTURAL FACTORS,
(CATEGORIZATION, STEREOTYPES, AND ATTITUDES)

- Understands the importance of and attains with sensitivity an assessment of client needs within the social and cultural context of the client.
- Provides an early communication of accurate and warm empathy in the relationship with ethnic minority persons.
- Is sensitive to variation within groups.
- Is sensitive to and does not over emphasize test scores which have not been appropriately normed or validated for ethnic minorities.
- Has and communicates positive perceptions of the ethnic minority person's group and culture.
- Challenges negative stereotypic views of ethnic minority groups in an effective manner.
- Maintains a sensitivity to the individual as a unique being and to the culture as a whole.

RELATING TO CROSS-CULTURAL COMMUNICATION FACTORS
(LANGUAGE, NONVERBAL, EMOTIONAL, AND ENVIRONMENTAL COMMUNICATION)

- Demonstrates sensitivity to different language patterns and seeks to understand the client's mode of communication
- Adjusts to the language proficiency of the client.
- Is mature, genuine, and congruent in relationships with ethnic minority clients.
- Communicates accurate empathy early in the relationship. Uses action-oriented counseling techniques and approaches.
- Uses group counseling and group work (including family and extended family) in counseling ethnic minority clients.
- Uses nondevaluative and nonstereotypical verbal and non-verbal language in communicating with ethnic minority persons.
- Disseminates clear and valid information about services and their benefits to ethnic minority persons.
- Exhibits skilled use of plain, clear, and operational language.
- Exhibits comfort and skill in communicating with family members.
- Has bilingual capability.

- Is skilled in the use of interpreters.
- Is skilled in accepting and clarifying client values and in helping the client envision developmental possibilities within the value orientation.
- Exhibits good, basic, and stable nonverbal attending skills.
- Provides or interacts in a communication setting which has elements which are familiar and stimulating to ethnic minority clients.
- Understands and relates effectively to the time and spatial orientations of ethnic minority clients.
- Knows, understands, and uses culturally appropriate ways to enter and leave situations, including farewells, and convenient times to visit.
- Is sensitive to client feelings, particularly fears of failure and culture conflict.
- Is skilled in reducing test anxiety and increasing test-wiseness of clients from ethnic minority backgrounds.
- Demonstrates an awareness of the limitations, potential cultural bias, and problems with the use of tests and assessment procedures with ethnic minorities.
- Focuses appropriately on the here-and-now and how it relates pragmatically to the client's future.
- Understands and accepts the reluctance of ethnic minority persons to verbalize their feelings fluently and to be introspective.

RELATING TO REHABILITATION CHANGE AND CULTURAL CONFLICT

- Exhibits sensitivity to fears of failure and conflicts, including the intermittent and cyclical aspects, of ethnic minority clients.
- Understands client risks and fears (e.g. loss of disability income and/or welfare, friends, role status in the family community).
- Understands that the upward mobility of ethnic minorities through rehabilitation is risky and complicated with possible negative side effects.
- Understands the likelihood of the ethnic minority client feeling "culture shock" in new, unfamiliar places and situations related to rehabilitation and around different and unfamiliar persons—particularly authority figures and peers.
- Is cognizant of potential danger periods in the rehabilitation process for ethnic minorities and is skilled in the alleviation of conflict in situations as soon as they arise.
- Exhibits skill in action-oriented counseling techniques and approaches.
- Exhibits skill in using group counseling and group work (e.g. involving the extended family) in counseling ethnic minority clients.
- Exhibits skills in focusing on goal-oriented problem identification that leads to concrete solutions.
- Knows ethnic minority persons who have been successfully rehabilitated and can relate the experiences and success of these persons to others entering and/or involved in the change process.

This listing of effective knowledge, attitude, and skill factors is, of course, a tentative framework for stimulating examination of the provision of services by rehabilitationists to disabled persons from ethnic minority backgrounds, for suggesting training objectives and methods, and for stimulating research. Indeed, the listing itself can be an object of research, for items can be added, subtracted, and otherwise combined and so forth.

IMPLICATIONS FOR THE HOWARD UNIVERSITY PROJECT

Implications refer to initiatives needed to clarify or to make complete understandings that have been presented.

If the Howard University Model to Improve Rehabilitation Services for Minority Populations with Handicapping Conditions is to realize its objectives, then cultural factors will need to be emphasized in the project. Efforts will have to be made to facilitate sen-

sitivity to client needs and differences through training and appropriate educational materials. Efforts to improve access to the existing systems will have to be tried and assessed along with exploration of the feasibility of alternate service delivery systems. Research and dissemination of findings on some critical issues will be needed. The model must be both synergistic and transcendent.

Need to Emphasize Cultural Factors

Relating the recommendations given to nurses by Bauwens and Anderson (1984, pp. 256-257), to the Howard University Project, there will be a need to emphasize cultural factors, specifically:

- Be aware of the ethnic minority client's cultural interpretations of health and ability, illness and disability, and health and rehabilitation.
- Identify sources of discrepancies between clients and their rehabilitation helpers in the meanings of health and ability, illness and disability, health care and rehabilitation.
- Be aware of the cultural values that affect the interface with and use of the rehabilitation system by ethnic minority persons.
- Evaluate the effectiveness of rehabilitation helper actions with clients from diverse cultural groups.

Need for Nonracist Practitioners and Cross Cultural Training

The four specific characteristics of nonracist practitioners suggested by Solomon (1976, p. 313), need to be evaluated for effectiveness as training and service delivery objectives:

- The practitioner should possess the ability to perceive in any behavior—other's or one's own—alternative explanations for that behavior, particularly those alternatives which the self might strongly reject as false.
- The practitioner should possess the ability to collect objectively, through the senses, those verbal and nonverbal cues which would help to identify all possible alternatives to the one which is most probable for a given client.
- The practitioner should have the ability to feel warmth, genuine concern, and empathy of people regardless of their race, color, or ethnic background.
- The practitioner should be able to confront the client when true feelings of warmth, genuine concern, and empathy have been expressed but have been misinterpreted or distorted by the client. In brief, the rehabilitationist should have synergistic and transcendent skills related to productive confrontation of differences (p.313).

In considering the dynamics and benefits of intercultural development, attention should be given to the model presented by Gudykunst and Kim (1984).

In addition, the training procedures outlined by Triandis and Brislin (1984) for improving cross-cultural awareness and effectiveness need to be examined against the objectives of the Howard University Project. These procedures include: information or fact-oriented training; attribution training; cultural awareness methods; cognitive-behavior modification procedures; experiential learning strategies; and interaction approaches.

Need for Influencing Responsiveness in the Existing System and Determining the Viability of Alternate Systems

Efforts will need to be made to increase the responsiveness of the existing rehabilitation systems to ethnic minority persons by hiring more minority persons at professional and support levels; bringing services to the geographic areas of the clients; and establishing meaningful service delivery objectives, monitoring actions, evaluating results, and making modifications as a result of appropriate feedback.

In terms of alternate systems of service delivery, the recommendations provided by Gellman (1966) and Solomon (1976) need to be considered, particularly Solomon's suggestion about relating service delivery to religious institutions.

Need for Research and Dissemination of Findings

The research questions posed by Usdane (1965) nearly twenty years back are still relevant and need attention. In addition, five social psychological cultural issues delineated by Sue (1983) seem worthy of exami-

nation. These are: etic vs. emic, mainstreaming vs. pluralism, equal opportunity vs. equality of outcomes, modal personality vs. individual difference, and presence vs. absence of racism today. Other issues which need research are policy/practice changes and multiple service delivery methods and accuracy in the translation of similar concepts with different meanings.

Among variables which also need study are the congruence of perceptions, cognitions, and motivations of ethnic minority clients and rehabilitation helpers; effective and ineffective interpersonal interactions in counseling and the supervision of counseling related to ethnic minority persons; and group dynamics in relating to the extended families of ethnic minority clients.

From a methodological perspective, there is a need for participant observer and case study approaches as well as survey and experimental approaches.

In the dissemination of research findings, there will be a need to balance ideological and practical viewpoints. Some attention needs to be given to the development of dissemination specialists and dissemination networks.

Need for a Synergistic and Transcendent Model

In implementing and improving the model, attention needs to be given to the principles suggested by Brayfield (1964) in his article on human resources development and his emphasis on how learning is influenced by expectations, reinforcement, modeling, achievement motivation, and problem solving.

In addition, the currency of existing philosophic principles related to rehabilitation (Wright, 1959), and their relevance to the rehabilitation of ethnic minority persons need to be examined, and means for actualizing these principles need to be developed.

FINAL NOTES

I have been professionally associated with rehabilitation for twenty-six years, first as a rehabilitation counselor in a state agency serving the visually disabled, then as a rehabilitation psychologist at a hospital specializing in the care of chronically ill patients and the rehabilitation of persons with severe disabilities. This was followed by work as a rehabilitation professor at two universities and as dean for student affairs whose responsibilities included the delivery of services to disabled students and the coordination of the institutional self-study required in implementing 504 regulations at one of the universities. I have also served as a consultant to many different rehabilitation programs, as the president of a state rehabilitation association, and as an editor of rehabilitation newsletters and publications.

My interests in cross-cultural psychology and counseling have been longstanding and have carried me to Japan, Taiwan, Germany, Jamaica, and Brazil in consultative relationships.

From my vantage point, the initiatives to facilitate ethnic minority access to and development through rehabilitation services have failed to reach a critical mass. Indeed, while some gains obviously have been made, I often wonder if we are now on the defense in trying to preserve the limited gains we have made.

It is hoped that the Howard University Project will break this plateau, pull together, synthesize, and transcend past efforts to facilitate accelerated movement toward the objectives of equal access and benefits for ethnic minority persons with disabilities as these relate to rehabilitation. This project would make a lasting difference in the quest of ethnic minorities for effective rehabilitation services.

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10 • Socio-Economic and Cultural Problems Affecting the Delivery of Rehabilitation Services to Hispanic Blind and Visually Disabled Individuals—Some Observations

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Abstract

The author discusses the problems associated with rehabilitative service delivery to blind and visually disabled Hispanics. Communication barriers are cited as a major problem. The need for an understanding of Hispanics' cultural background, family loyalties in terms of their effect on service delivery to the group, and the acceptance of rehabilitation is also discussed. The State Commission for the Blind of Texas has made significant gains in recruiting and employing professionals to meet the needs of the blind and visually disabled Texans.

There is a common assumption that Hispanics are not amenable to therapy or counseling; that they do not possess the motivation necessary to enter into a counseling situation with expectations of receiving benefit from the service delivery; and that they will not contribute to the success of their rehabilitation program. In reality, Hispanics will accept help, counseling, and services if their cultural identity is respected and their individuality is maintained and recognized. In the area of rehabilitation services for the blind and visually disabled persons, the State Commission for the Blind of Texas has worked steadily toward the development and

implementation of a service delivery system that effectively meets the needs of all blind and visually disabled Texans. Recognizing that blindness, like other disabilities is no respecter of ethnic origins, the agency's vocational rehabilitation efforts are based on a need to serve Hispanic clients in a manner that will produce the greatest results for the client.

Recognizing that language is one of the most obvious manifestations of any culture, vocational rehabilitation professionals (teachers and counselors) must acknowledge the crucial role this plays in service delivery to blind and visually disabled persons who are Hispanic. The overall importance of culture in understanding, regulating, and examining human behavior and reactions to a disability such as blindness cannot be overstated. The basic assumptions underlying most intervention efforts are exemplified by programs that either deny certain aspects of the Hispanic culture or propose corrective measures that separate the individual from his or her cultural background. The raising of the cultural sensitivity of professionals involved in the vocational rehabilitation field is a necessary step towards providing culturally valid services to the Hispanic community. Integral to the understanding of the Hispanic disabled person is the need to understand the impact of language and culture on that individual. Studies spanning nearly half a century have consistently shown that the Hispanic population is this nation's most undereducated minority. In many ways, they are also this nation's most misunderstood ethnic group. To put it as another author did, "monolingual, English-only instruction has had at least as devastating an effect educationally on Hispanics as slavery and segregation had on Blacks" (Yzaguirre, 1981).

BARRIERS TO REHABILITATION

To some extent, the Hispanic outlook on life is reflected in the Spanish language. One Hispanic author wrote, "We tend to be very gentle with ourselves, using the diminutive when talking about ourselves and our dear ones. We approach a level of gentleness and tenderness which is unique to our people" (Enrique, 1980). In the balance of understanding stress and pain, mental health problems, aberrations in behavior, or even disabilities such as blindness, it is quite common to hear a Spanish-speaking person refer to a blind individual as "un pobre ciegito" (a poor blind man). Illness, faults, and even disabilities become extensions of the person and are oftentimes treated with nurturing, sympathetic kindness, and comfort. Many times, this protective covering poses a problem for vocational rehabilitation counselors or teachers who are trying to move the blind person toward independence and a maximum level of self-sufficiency that may be afforded through employment assistance efforts that allow the blind person to secure a job.

Oftentimes, family loyalties and other cultural factors (including religion) foster dependency and isolation. To members of the rehabilitation agency, such as the Texas Commission for the Blind, this poses added challenges in working with Hispanic clients who are hesitant to accept the training and counseling needed for their rehabilitation. In the rural areas in Texas, for example, vocational rehabilitation teachers and counselors must deal with the fact that Hispanic clients are oftentimes unwilling to leave their home area for specialized training and employment opportunities. There is a tendency by family members to protect the blind relative and keep him or her close by. The basic tenet of vocational rehabilitation, that of "independence," then becomes a sensitive issue when dealing with the client and the family members. It becomes crucial for the vocational rehabilitation worker to explain the value of independence for the disabled person without startling family members or attacking the role that the family plays in this culture.

Several other key issues surface when dealing with Hispanic blind clients. Before anyone can examine the uniqueness of disabled Hispanics, it becomes vitally important to examine the following factors:

—the role of "la familia" in the Hispanic culture
—the traditional views of disabilities and attitudes toward rehabilitation, independence, and counselor/client roles
—the impact that a disability such as blindness has, not only on the individual but on the family unit
—the complications of poverty, minimal

education, and language barriers on the success of a rehabilitation plan

—the role that religion, folk healers, and other sources of support play in meeting the disabled person's needs.

There is no question that delivering effective vocational rehabilitation services to blind and visually disabled Hispanic clients is a challenge to any professional. Efforts in Texas, through the State Commission for the Blind, have centered on the need to recruit and employ qualified professionals who either have a Hispanic background or an understanding of this group's cultural foundations. Approximately 20% of the agency's staff is Hispanic. With offices located throughout the state, the Commission maintains operations in areas that are predominantly Hispanic and are served by agency personnel equipped to meet special needs.

Vocational rehabilitation (VR) personnel employed by the Commission serve approximately 35-40% Hispanic clients on agency caseloads. While most of these individuals are located in the Rio Grande Valley, El Paso, Laredo, and San Antonio, large pockets of Hispanics are located throughout the state and on caseloads served by the Commission. Individuals working with Hispanic clients must readily recognize that their approach to VR must be tailored to the client's needs. In the case of Hispanic clients, VR professionals must place a strong emphasis on the involvement of the family throughout the entire process of rehabilitation. Staff must recognize the customs and values of Hispanic clients so as not to antagonize them and reduce the chances for success during the entire rehabilitation program. It is just as important to recognize the traditions and norms so as not to get bogged down on a traditional methodology to the exclusion of results. Finally, it is incumbent upon the VR teacher or counselor to want to learn and understand the social and cultural configurations of Hispanic clients.

The uniqueness of the vocational rehabilitation program as compared to other social service programs rests on a proven service delivery model that requires maximum participation during each step of the process by both the client and the VR professional. The direct benefit of the VR program to society is reflected in the fact that there is more than a nine to one dollar return on every tax dollar spent. How these services are offered to Hispanic blind persons is an issue that continues to draw added attention.

While there is no proven formula for an effective approach to working with Hispanic disabled persons, organizations such as the State Commission for the Blind in Texas have found that one of the most appropriate means is to employ professionals who possess a valid understanding of this culture. The issue of language barriers is quite obviously an important consideration to the establishment of an effective service delivery system. The attitude that Hispanics have toward dealing with their disabilities must also be considered and woven into the service delivery modality. Also, there must be a continued emphasis on forums of this nature that will allow for open dialogue and exchange of ideas concerning the needs of disabled Hispanic citizens and effective means of delivering rehabilitation services.

This presentation could not be complete without an account of an incident that captures the essence of this issue, particularly as it relates to the importance of language and working with Hispanic clients. The story goes something like this: A VR teacher working with the Commission for the Blind recalls the time she went to visit a Hispanic family on her initial contact. She did not know that the family was fluent only in Spanish, and she was not prepared for what was to come. Upon arriving at the home, the teacher knocked on the door. When greeted by one of the family members, the teacher thought it would be a good opportunity for her to test her limited Spanish. When asked who she was, she responded: "I'm from La Comision De No Ojos." Quickly this sent a chill down the spine and soon several people were at the door with a definite sense of alarm. Who was this person who acknowledged herself as being a representative of an agency without eyes? Was she there to remove someone's eyes? What the teacher meant to say was: "I'm with La Comision Estatal Para Los Ciegos."

After awhile, both the client and other family members understood that the stranger was there to do an initial interview and to ascertain what types of services the Commission could offer to one of their family members who was blind. They soon realized that the purpose of the visit was not to remove someone's eyes.

Looking back, there is obviously some humor in the embarrassing situation. However, viewed in a different and more serious vein, the entire situation points out a rather significant aspect involved in dealing with persons of the Hispanic culture who adhere to their native language.

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11 • The Emerging Role of the Disabled Hispanics

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Abstract

The state of "double jeopardy" which disabled Hispanics are in is discussed in this article. The economic, social, and educational problems of the increasing population of Hispanics in the United States suggest the need for more meaningful rehabilitation services. The author outlines factors affecting rehabilitation: the role of the family; personal network among Hispanics; the male attitude; intake procedures; and language barriers. Evidence in support of the critical need for bilingual, bicultural rehabilitation professionals is provided. The author concludes by listing the recommendations from the conference on the Special Rehabilitation and Research Needs of Disabled Hispanic Persons in 1983.

The term "Hispanic" represents diverse populations that include, in large numbers, Mexican-Americans, Cubans, Puerto Rican mainlanders, and Puerto Rican islanders. As noted by Linsky, Arnold, and Hanoch (1983), cultural differences can be assumed to exist among the various Hispanic populations. Further, it seems reasonable to hypothesize that such cultural differences between and among Hispanic populations are historical in origin, but are also affected by geographic region, socioeconomic status, educational level, and rural-urban locale. Therefore, it becomes imperative to scrutinize closely all research which presumes to reflect the "Hispanic" culture.

Hispanics constitute a growing population in the United States. The 1980 census indicated a substantial increase from previous years. They now number in excess of 14½ million and represent a significant proportion of the American population.

However, data on the number of Hispanic disabled is practically non-existent. Based on limited data and using inferential methods, it is estimated that there are 2.5 million Hispanics of working age who are disabled. However, only 25,000 persons of Hispanic origin were rehabilitated by public programs in 1981.

The Hispanic disabled represents a real challenge to rehabilitation professionals and administrators. If we are to provide meaningful rehabilitation services, we must understand the cultural characteristics discussed by Rivera and others.

La Familia: The Spanish family provides the primary support system for the individual. Despite the many positive factors of family support systems, one drawback is the occasional overprotectiveness that tends to dilute efforts towards independence by disabled individuals.

Personalismo: This relates to the personal network among Hispanics as opposed to the dependence on institutionalized direct delivery systems. The absence of Hispanics in key positions mitigates against an effective delivery system because of their reliance on personal contacts and acquaintances. Thus, many Hispanic clients are reluctant to share relevant information with non-Hispanic rehabilitation counselors, since the latter is perceived to be an "outsider."

Machismo: The male attitude of full responsibility for behavioral guidance of the family. Within this context the male member of the family is responsible for providing resources to the family and for making major decisions affecting the family members.

La Palabra: "A man's word is his honor." The commitment to a verbal contract is very important to Hispanics. Performance based on one's word as opposed to written contracts is of paramount importance and should be considered in any rehabilitation program initiated on behalf of Hispanics.

Language: There is limited information available in Spanish regarding the vocational rehabilitation program. The communication barrier is critical since there are so few bilingual and bicultural professionals in rehabilitation.

Clearly, the emerging issues in our efforts to serve this population revolve around 1) existing barriers to rehabilitation; 2) development of innovative service delivery systems; and 3) basic research issues. Of particular concern, however, to rehabilitation practitioners is the need to develop specialized programs to overcome immediate barriers to rehabilitation and employment.

A paper by Rivera (1983) (published in the reprint from the Mary Switzer Memorial Monograph entitled Social implications for rehabilitation planning: Blueprint for the 21st century) summarized the situation in the following manner:

> There appears to be an underutilization of rehabilitation services by disabled Hispanics. The reasons for this is the barrier to access to these services. The solution is the need for outreach and advocacy. Rehabilitation counselors need to go into the community (including the home) and get acquainted with community leaders, and the clergy, informing them of what rehabilitation services exist for disabled persons and how to access the system. All too often potential clients do not understand the application process to enter a vocational rehabilitation program nor their rights as citizens under the rehabilitation laws and regulations.

One obvious solution is to train more bilingual, bicultural professionals and place them in areas where there is a high concentration of Hispanics.

Lafitte (1983) recommends that current training programs in rehabilitation introduce into their curriculum undergraduate and graduate courses in the language and culture of Hispanics. Such course offerings would be of significant value to rehabilitation training programs located in areas with a high concentration of Hispanics (e.g. southwestern United States, metropolitan New York City, southern Florida, and Puerto Rico). Lafitte also champions an assertive and well-organized recruitment program to attract Hispanics into their rehabilitation training program.

A conference on the Special Rehabilitation and Research Needs of Disabled Hispanic Persons (1983) provided a variety of recommendations regarding rehabilitation issues and research needs. Several of these needs are listed here:

1) More accurate data on the numbers, types of disabilities, and acceptability of services in order to design effective rehabilitation services for the disabled Hispanic person.

2) Research on the effectiveness of various rehabilitation approaches to eliminate barriers which preclude acceptance and utilization of rehabilitation services and technology by this population.

3) Research of innovative approaches to extending rehabilitation services to migratory workers and disabled who live in rural areas.

4) Research should include elderly Hispanic persons whenever rehabilitation issues are addressed.

5) Development of mechanisms for involving the disabled Hispanic student in the rehabilitation process prior to the end of his or her secondary school education.

The above are but a small number of ideas for programs that need to be undertaken but one other important need exists. The inability of many Hispanics to communicate easily in English seriously obstructs access to rehabilitation services and employment.

For many disabled Hispanics, the educational stability so essential to learning English is often missing. This problem is twofold and solutions must be sought from a dual perspective. Knowledge of English as a second language must be pursued and more bilingual and bicultural services must be available from the providers of rehabilitation services. This is certainly an attainable goal by the year 2000.

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12 • Overcoming

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Abstract

The authors make a comparative analysis of the treatment of blacks and the disabled as inferior citizens. They also discuss the role the media plays in perpetuating the attitudes and stereotypes reflecting the prejudice toward both groups. Blacks and disabled individuals have the responsibility of working more closely with the media in providing information on the rehabilitative services available and in promoting a more realistic perspective of their potential.

Being black in the United States is still a disadvantage. Being disabled in the United States is also a disadvantage. Being both black and disabled puts a person in double jeopardy. And, unlike the popular game show, this condition lasts a lot longer than a few money-making minutes.

Traditional prejudice still forces black people away from opportunity and into low-paying, low-prestige positions in society and the work place. Prejudices of a different sort, often based on good intentions, have the same detrimental effect on people with disabilities. Legislation and landmark court decisions have served to blunt the effect of these ancient bigotries, but society's attitudes and the stereotypes they engender live on.

Unfortunately, these attitudes and stereotypes are perpetuated—perhaps inadvertently—by the news and entertainment media. I say "perhaps inadvertently" because media depictions of black and/or disabled people are both a cause and a result of the general public's view of these population groups. For example, a main character in a dramatic presentation may acquire a disability as a result of accident or illness, but there is always the glorious day of the total cure because viewers are uncomfortable with wheelchairs or white canes. Likewise, a news story about a black star in sports or business usually tells how this person fought his or her way out of the ghetto because many readers believe all black people begin in the ghetto. In both instances, the media are at once reflecting and feeding traditional beliefs—beliefs that must be changed if we are ever to gain the status we seek, that of full and equal participants in the life of our nation and our community.

I must say here that the fault does not lie entirely with the media. We who are black

and/or disabled often contribute to the situation. We naturally welcome praise for an achievement and the publicity that might come with it. But if we are not careful, we may lend support to the idea that success is the exception, not the rule, for people like us. We always say that equality of opportunity is our goal. We want to succeed or fail on our own merits, not because of some prejudice or special affirmative action program based on race or disability. As long as the achievers among us are singled out as atypical, that equality will be difficult to realize.

What can we do? For one thing, we can work with the media on a continuing basis, not just at the time of a major event. Communication and exposure can sweep away myths and create understanding of the real dimensions of our life situations. In recent years, school integration and the inclusion of black people in TV commercials, comedies, and dramas have shown white Americans that their black neighbors' abilities, strengths, and weaknesses are not really different from their own. Any disabled person can tell you how a personal encounter has changed someone's distorted view of disability. But on a one-to-one or small group basis, we will never get our message to everyone in the nonblack or nondisabled world. The media can and must take on a more active role in this education process.

In order for this to happen, people in the media must themselves accept certain facts, facts which are often startling when first pointed out. For example, the only thing a blind person cannot do is *see*; the only thing a deaf person cannot do is *hear*; the only thing a wheelchair user cannot do is *walk*. Of course, a particular physical limitation may make some activities impractical. I doubt, for instance, that we will ever see a blind person win the Indianapolis 500. But the limitation affects only that particular physical ability; it does not automatically augment or diminish a person's intelligence, ambition, emotional development, or sensitivity. Similarly, people in the media must accept the fact that Dr. Shockley is indeed wrong; nothing in blackness creates an inferior person. It is centuries-old prejudices and misconceptions, not disability or blackness, that have spawned and nurtured the image of the helpless handicapped and below-average blacks. Media people who realize this—and many do—can be of great help to us in fighting the prejudices and correcting the misconceptions.

I am pleased to say that some progress is being made. Earlier I mentioned that black people are finally being given more realistic exposure on television. Even disabled people are doing better in this regard. I would like to give an example. Years ago, in an episode of the "Barnaby Jones" detective series, the killer pretended to be blind. Barnaby, in his wisdom, saw through the deception when, during a visit to the man's home, he noticed that the television set was warm. Generally, blind people do not "watch" television although, as is true of many sighted people, they may "listen" to it or have it on for company. In this example, however, Barnaby's suspicions proved to be true.

This bit of stupidity is in fine contrast with something now being done on the soap opera "Guiding Light." For several months, one of the characters has been a blind woman who runs a kind of adjustment or rehabilitation center. Though she may not stay in the story, her independence and generally "normal" way of life has been well presented.

Rehabilitation of the type depicted in "Guiding Light" is often a necessary part of a disabled person's life. We consider it a community resource, somewhat similar to adult education classes, Red Cross first aid training, and recreation programs provided by a city or state. As with such resources in general, many who could benefit from them do not know they exist or how they can be useful. Here again, the media can be of tremendous help. Feature articles and talk shows could focus on state and local agencies, their programs, successes, and their failures. When such an effort is undertaken, I would urge that the clients of these agencies be portrayed not as "needy" and "dependent" but as potential taxpayers on the road to productivity. If media staff members really want to be helpful, they could volunteer to prepare public service announcements about rehabilitation programs and run them during peak listening and viewing periods—not just at 3:18 Sunday morning.

Several years ago, the disabled community made headlines by demonstrating at the offices of the U.S. Department of Health, Education and Welfare. The purpose of the demonstration was to bring about regula-

tions prohibiting discrimination against disabled persons in federally supported programs and activities. One of the men handling publicity for the demonstration had cerebral palsy. His work took him to the studios of Washington's Channel 4. When he left he shared a taxi with Jim Vance, a newsman who is black. As they discussed the demonstration—the reasons for it and the benefits to be derived from the hoped-for regulations—the man with cerebral palsy told Mr. Vance: "We are today's niggers." By that he meant that we, too, had been considered second-class citizens for centuries; that we, too, had been ignored or relegated to "special" categories, and that we, too, were beginning to assert ourselves and were thereby incurring some of the backlash that was so familiar to black Americans.

Like our black brothers and sisters, disabled people want to be respected as a population group and as individuals. We want to break down the barriers that keep us in those "special" categories. We want to be free to participate fully in all aspects of living. We have a long way to go, but the example of our black brothers and sisters is an inspiration. Like them, we *will* be successful. *We, too, shall overcome!*

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13 • Images and Identity—In Marketing Adults with Disabilities in the Media

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Abstract

The media, one of the most powerful tools of communication, has a significant influence on the development of attitudes and stereotypes held by the general public toward the disabled community. This article presents an overview of the marketing strategies and recommendations instituted by the President's Committee on Employment of the Handicapped to ameliorate these negative images and stereotypes by implementing public relations efforts which depict and demonstrate the positive and multidimensional abilities of persons with disabilities. Included also are alternative constructive guidelines which emerged from an international media seminar sponsored by the United

Nations. The guidelines were designed to facilitate the accurate portrayal of individuals with disabilities while still encouraging the range of creativity and individuality inherent in the media industry. Information is also provided to disability organizations and individuals with disabilities on a plan of action for developing skills to gain access to the media.

The media/entertainment industry is one of the most powerful tools of communication. However, its recognition of persons with disabilities as complete individuals is long overdue (National Easter Seal Society, 1981). Whether one views a medium as a window on a wider world or as a mirror on one's own surroundings, the media's capacity to examine and communicate people, places, and ideas is unequalled (United Nations, 1982).

The lack of positive public images hampers the quest by persons with disabilities for social and economic integration. What the public perceives as reality and how it reacts to certain groups often define that group's "place" in society. The milieu of that "place" can be characterized by restrictions and limitations which the public generally associates with disability.

Society's major image makers generally include non-disabled male leaders in government and business. Through the media, these image makers influence the public by projecting their opinions of the disabled formulated by their limited experiences. Consequently, these stereotypes formulate the barriers which segregate the able-bodied from persons with disabilities. How the media portrays persons with disabilities truly influences the views and attitudes of society (Media Office, 1985).

Telethons, fundraisers, and television specials present images of need and vulnerability which underscore an identity of dependence. Motion pictures, live stage performances, and other forms of entertainment frequently depict persons with disabilities as extremely brave and perservering or alternatively as emotionally unstable, desperately searching for love and acceptance. News stories generally show persons with disabilities as outcasts. They are either dissatisfied with society's response to their needs or are achieving goals despite insurmountable odds given the degree of severity of their impairment. Such portrayals of persons with disabilities as superhumans may inadvertently create confusion or doubt in the minds of the general public. Leslie A. Felder (1982) explains that such:

> . . . ersatz sagas of heroic groups, then, merely turn upside down rather than dissolve the sense of immitigable difference which lies at the root of our troubled response to persons with disabilities, by making them super rather than human. Worse, by their relentless emphasis on the positive, such stories exacerbate rather than release our negative feelings of hostility and guilt, leaving the public more conflicted than ever.

Obviously, the public sees disability in terms of neediness and lack of self-determination. Consequently, programs are organized which treat persons with disabilities as dependent persons incapable of fully participating in society. The existence of programs espousing this attitude in turn validates the public image of disability.

Does the communication industry have a responsibility to change attitudes, images, and expectations of the general public toward people with disabilities? Concerned citizens and the disabled community think so. Maurie Goodman (1979), a performer, stated it bluntly: "The industry has an absolute responsibility. Television is the single most moving force in modern history. It has the power to change minds, attitudes, and lifestyles. There is a responsibility that comes with that" (Littinson, 1985).

Representatives from the disabled community met with the decision-makers of the National Broadcasting Company, Inc. (NBC) to enlighten them in regard to their responsibility. Critical of NBC's portrayal of the main character in a particular movie, Alan Toy, a performer with disabilities, testified on behalf of the disabled community: "What we want to see is more realism and normalization and less of the superhero image. Our condition should not be used as a reason for inspiration. We do not want to be inspiring. We just want to be accepted like everyone else" (Littinson, 1985).

In light of all of this, it is no wonder that the business world ignores disabled adults as consumers and media performers. Indeed, because of a poor public image, persons

with disabilities are practically nonentities in the world of commerce and entertainment. Quite naturally, the people who sponsor television shows and finance theater and film productions are reluctant to show individuals with impairments in realistic roles. Those who underwrite advertisements to market products understandably fail to recognize persons with disabilities as part of the buying public.

This was made clear in 1979 when Birnak, an advertising firm, contacted major corporations concerning the appearance of persons with disabilities in their television commercials. The following are statements from some of the responses received:

> . . . we would not wish to have our advertising messages misinterpreted by those who may feel that we sought to capitalize on the physical handicaps of individuals in order to 'sell a product.' . . . But showing them in our commercials is a different story. It's a sad fact of life, but if we put them in our advertising, we are criticized for taking advantage of them commercially. People accuse us of seeking sympathy by placing them in advertising (Littinson, 1985).

This problem of image and identity is important to fully understanding why integrating persons with disabilities in advertising, product marketing, and other manifestations of social equality and public acceptance have been confronted with barriers.

Also supporting the "place" of disabled persons in contemporary society is the absence of reliable statistics about the disabled community. The business world lacks information which is necessary for establishing a marketing identity. Who are adults with disabilities? Where are they? What are their incomes? What do they need, buy, and watch on television?

Moreover, businesses ignore posing such questions in marketing research. Statistics available from government sources are not the type that stimulate businesses to perceive persons with disabilities as part of the buying public. Thus, persons with disabilities have no marketing identity. As a result, manufacturers and providers of services (including the entertainment industry) avoid addressing adult disabled persons as consumers to seek out and win.

Given this situation, can a better, more realistic image and marketing identity for persons with disabilities be possible? The efforts of the President's Committee have shown that it can happen. Our public service advertising campaigns have long been designed to offset traditional attitudes toward adult persons with disabilities. Starting in the mid-1970's we developed a marketing concept which was revolutionary.

Working with the faculty and students from the School of Visual Arts in New York City, we designed materials for print and television advertising which presented people with disabilities as capable, productive persons. With an equal opportunity, they would be just as successful as able-bodied persons. To enhance this positive image and identity, our marketing strategy involved far more than merely featuring a casual picture of people with disabilities. Visually and verbally—even when it conflicted with prevailing professional wisdom—each advertising product focused on the individual qualities of adults with disabilities, their rights and their interests.

The more recent advertising campaigns of the President's Committee have been unique in another respect. We have purposely addressed a dual audience—business people and individuals with disabilities—because the image and identity which persons with disabilities have of themselves go hand in hand with the public's image. Persons with disabilities were presented as positive role models. By featuring in our advertising materials adults with disabilities who were competing successfully in society, we strived to encourage other individuals with disabilities (especially those who could benefit from further education and additional jobs skills) that it was possible for them, too.

Make no mistake, getting society to absorb a new image and identity for adults with disabilities is larger than the resources of any one agency or institution. Nevertheless, the impact of each effort can be quite pervasive. With the limited resources and small budget available to the President's Committee, we provide some 4,000 businesses, trade and consumer publications with good quality, attractive, and effective public service materials.

Producing a public relations program for disabled adults (1979) was just one of the

few relevant products developed. Businesses and professionals in the media are now contacting the President's Committee. These individuals have seen our advertisements and want to know how to effectively reach adults with disabilities as consumers, as an audience, and as potential employees.

In the years since the President's Committee first instituted a modern marketing plan, we have learned that we were in the forefront of using marketing tools to further a social cause. Academicians discovered in the 1970's that marketing could be adapted to social programs with benefit to the programs and its recipients. Nowadays, there is strong interest in the use of marketing concepts in the non-profit world. In May 1985, the President's Committee will collaborate its efforts with the National Easter Seal Society and the American Association of Disability Communicators to explore and expand the use of marketing concepts at a communications seminar, "Media and Disability Seminar," scheduled to be held in Chicago.

We have also been fortunate to see the development of leadership organizations such as the Screen Actors Guild which functions as a liaison between the disabled community and the media/entertainment industry. The United Nations convened in Vienna during the summer of 1982 with a group of specialists from around the world to formulate guidelines for the inclusion and portrayal of disabled people in the media. While guidelines were developed as suggestions, those attending the convention encouraged the range of creativity and individuality that is inherent in the media industry. These guidelines, as revised by a subgroup on the basis of the world-wide review, are as follows (United Nations, 1982):

1. Depict people with disabilities at home, at work, at school, at leisure, and in a variety of other ordinary social and physical situations.
2. Acknowledge the natural curiosity and occasional awkwardness that may develop in social situations involving disabled and non-disabled individuals. Where appropriate, provide positive examples in which such curiosity is satisfied and in which awkwardness is lessened.
3. Include people with disabilities as part of the general population in media products in addition to those in which their story is the primary focus.
4. Avoid presenting people with disabilities as dependent or pitiful. Other stereotypes to be avoided include presenting people with disabilities as inherently saintly or asexual, gratuitously dangerous, or uniquely endowed with a special skill due to a disability.
5. Consider carefully the words used to describe or characterize disabled individuals. Recognize and avoid phrases that may demean these individuals (e.g. blind as a bat, deaf and dumb).
6. Portray people with disabilities in the same multidimensional fashion as others.
7. Present the achievements and difficulties of people with disabilities in ways that do not overemphasize the impairment, exaggerate, or emotionalize the situation. For example, in news stories and documentary reports, the fact of a person's disability should be reported only when it is directly relevant.
8. Information should be provided to the public about prevention and treatment of impairments that lead to disability, as well as the availability of services for people with disabilities and their families. This can be done through public information campaigns and also can be integrated into general media products.

Recommendations were also made to organizations of and for people with disabilities. They include the following (United Nations, 1982):

1. Promote and make widely available to the major media the guidelines developed by this seminar. Whenever possible, organizations are urged to communicate the guidelines through direct personal contact with those individuals responsible for developing and producing media.
2. Establish a system by which media presentations about persons with disabilities can be systematically and critically examined and by which the results of such examination, positive and negative, is regularly reported to the media.
3. Collect examples of outstanding pre-

sentations of subjects related to disability in the different media forms and bring them to the attention of all media.

4. Organize seminars of persons with disabilities, advocates, and media representatives to develop and implement plans for promoting public awareness, understanding, and acceptance of people with disabilities. Such plans should be reviewed and revised regularly.
5. Establish an information service to provide personal and practical assistance to the media in their efforts to develop products for and about persons with disabilities.
6. Develop a network to encourage and train people with disabilities to participate on all levels and in all forms of the media. Include in-service training programs, seminars, workshops, and informal clubs in which persons with disabilities may develop their skills in all fields related to the media. These different forums should, whenever possible, include participation by people who are not disabled.
7. Ensure that all institutions and organizations dealing with training and research in fields associated with the media incorporate disability-related subjects as a regular part of their work.
8. Make use of mobile media units where appropriate to inform about prevention, education, rehabilitation, and training of disabled persons.
9. Ensure that people who are disabled, their families, and communities are taking an active part in media activities through group discussion, community activities, and feedback to the media (e.g. radio forums, teleclubs, reading groups, cineclubs, and viewing sessions for and by the target groups).
10. In addition to the mass media, give attention to oral and other traditional forms of communication, especially in areas not regularly served by the mass media.
11. Coordinate, on a national basis, all actions taken in regard to the media with other organizations of and for disabled persons.

Anyone contemplating developing a marketing plan must keep one thing always in mind: You cannot be successful by simply presenting whatever image or identity you find appealing. The public generally has a point of acceptance beyond which unusual or unfamiliar images will have an adverse affect on the advertiser. Marketing strategies can be agents for social change, but successful ones are those which stay abreast of what the public can or will tolerate.

Examples of advertising captions from different materials developed over the years by the President's Committee illustrate this principle. In the 1950's and 1960's, the depersonalized slogan "Hire the Handicapped—It's Good Business" was used extensively. In 1975, we developed a more personal slogan: "I do, I think, I feel." Advertisements developed later did not utilize catchy remarks or slogans. Instead, they developed various captions to highlight different public service materials.

The headline of one printed material proclaims: "I have the same right to live, I want a piece of the same pie and damn it, I'm gonna get it." The quote is from a past Handicapped American of the Year, and it forthrightly expresses his view on his place in society. It's a strong advertisement; one that would not have been possible a few years ago. Yet it presents the public with a new and acceptable image of disability.

From a marketing standpoint, adults with disabilities are a solid "product." The millions of dollars in donated public service space for the President's Committee's advertising materials verify this. Marketing an image and a new identity for adults with disabilities is possible with planning, foresight, creativity, and networking.

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14 • New Assistive Technologies and the Nonwhite Disabled

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Abstract

New assistive technologies can enable the nonwhite disabled to experience increased efficiency in environmental interaction, thus providing them with an easier means to obtain education, employment, and independence. However, small entrepreneurial businesses which market specialized technology to a consumer group that is neither large nor lucrative are forced to charge high prices. As a result, new devices are beyond the reach of the majority of the nonwhite disabled, one of the least financially stable groups in society. Without intervention, a convergence of race, socio-economic status, and disability seem destined to consolidate the nonwhite disabled as a disadvantaged group in the computer age. A trilateral partnership between disabled individuals, service providers, and manufacturers could help enlighten attitudes concerning the innovative but unfamiliar new technologies while it highlights issues of cost, availability, and equity of access.

The revolutionary effects of the computer age are especially relevant to the nonwhite disabled. By enabling persons with disabilities to interact with the environment in a host of new ways, possibilities emerge that have never previously been considered. The new assistive technologies can release the potential "locked" within disabled individuals by their impairments. These technologies have the capability of dramatically extending the range of educational and life opportunities of disabled individuals and enable them to live more independent lives and hold jobs previously closed to them. The silicon chips that activate an industrial robot can equally well be used to control an inter-

active robotic device for a severely disabled person. Similarly, if a paralyzed individual has at least one consistent body movement such as the ability to blow on a pneumatic straw or wiggle a head pointer, then that individual has the capability to design a skyscraper or attain any other major achievement that modern computer usage provides.

A surge of interest in special education and rehabilitation has occurred in recent years. This is reflected in the allocation of funds to these areas. According to Kakolik (1983) approximately $4.6 billion was allocated to special education by federal, state, and local education agencies in 1976. By 1983, the total funding had increased to more than $12 billion with a projected increase by 1985 to approximately $15 billion. A substantial portion of these funds will go to courseware aspects. According to Blaschke (1985), "the National Audio Visual Association has projected a higher rate of increase in per pupil expenditures in special education for instructional equipment and materials than in education generally, from $367 million in 1982 to $650 million in 1985." Blaschke suggests that this flow of funds provides a strong inducement for the private sector to attempt to penetrate or expand its market share in special education. A high priority for the National Institute of Handicapped Research (NIHR) has been to involve private industry in the production and marketing of equipment that assist persons with disabilities to live independently. In order to direct major emphasis to this aspect they have developed linkages with the Electronic Industries Foundation (EIF). Industry's role in marketing assistive devices has been identified as a key to the success of these efforts.

The scientific community is predictably interested in the interaction between the disabled and the new technologies, for this is an era when the interface between man and machine is developing a whole new significance. Just as the performance of highly modified cars on the race track supplies valuable insights and improvements to automobile assembly, so can the adaption of technologies to perform human tasks provide valuable insights into the area of man-machine interface, robotics, and artificial intelligence. The net result of the advancement in scientific knowledge could benefit society as a whole. It is of paramount importance, however, that high-tech experiments with assistive devices result in more tangible outcomes than merely advancing scientific knowledge and benefit the disabled population for whom the devices were originally developed. Production and marketing initiatives from industry are of crucial significance.

A distinction must be made between the assistive technologies with which this paper deals and technological developments that involve bioengineering systems and surgical processes. The latter are exemplified by experiments in "functional electrical stimulation" which are currently taking place at the Veterans Administration Medical Center in Cleveland, Ohio. They involve the surgical implant of electrodes to activate paralyzed limbs. These developments currently represent the ultimate in man-machine interface, whereby the machine becomes part of the man. Assistive technologies, however, are essentially different. Although they are tailored to an individual's functional ability, they remain external to the user and, unlike bioengineering processes, represent nothing more than specialized "tools" that man has developed to deal with the environment. Leifer (1983) states that "the evolution of mankind can be measured in terms of our mastery of tools. Tools allow us to control our environment in ways quite beyond our native ability. Hand tools have become machine tools and now (with robotics) machine tools have evolved hands." The new assistive technologies for the disabled can be classified into five overlapping categories.

1. ADAPTATIONS TO THE BODY AND SENSES: leading in some cases to greater physical maneuverability and/or a greater degree of success in environmental interaction and in other cases to a greater communicative ability.
2. ADAPTATIONS TO THE PRIVATE LIVING ENVIRONMENT: allowing a greater degree of control and increased independence.
3. ADAPTATIONS TO THE EDUCATIONAL ENVIRONMENT: leading to the acquisition of skills and improved abilities.
4. ADAPTATIONS TO THE WORKPLACE: leading to increased employment opportunities.

5. ADAPTATIONS TO THE PUBLIC REALM: leading to greater accessibility.

In providing an overview of some new assistive devices the aim of this paper is not simply to eulogize over the achievement of technology, significant though these may be. Issues of availability, cost, and equity of access must be considered in any discussion of assistive technologies for the nonwhite disabled. The purchase prices (as of September 1985) of the devices are discussed in the remarks that follow the description of the various technologies. Issues of funding, advocacy, and consumer education are considered within the concluding remarks. The production of assistive devices is a volatile industry in which technologies compete, therefore, the information contained in this paper is time-sensitive.

An initial problem in the development of most technologies is that of cost. When a new technology first appears on the market the price of the prototype models is normally prohibitive to all but a few. In time, as a result of standardization of design and an increase in production level in response to (an anticipated) demand, the price may decline considerably. This situation is particularly pertinent in relation to the new assistive technologies. Often an assistive device is the sole product of a small company. Unger (1983) emphasizes the role of independent inventors in the production process and asks "Who produces the innovative and appropriate technology? Is it our universities? Is it our IBMs? Numerous studies in the last 20 years have shown again and again that independent inventors and small businesses are the predominant producers of the new, innovative technology in this country." Many of the devices described in this overview are marketed by small companies that have been formed by an individual just to get an invention going. Small entrepreneurial businesses are notably vulnerable with high overheads and this is reflected in the price of the product. The problem is compounded by the fact that the disabled population represents a very specialized market which is neither large nor lucrative. As a result, the initial cost of an assistive device may be prohibited to many of the disabled population who have no means of securing the purchase price.

Issues of equity arise with considerations of availability and cost. Already within the computer revolution the question of who are the beneficiaries of the new technologies, is being asked. Unequal access to computer and telecommunications technology increases the disparities between the privileged elite and the less affluent, thus minorities and the disadvantaged are being left behind. This raises disturbing questions for the nonwhite disabled for, as Bowe (1983) reports, they represent one of the least financially stable groups in American society.

Technology that helps integrate the minority disabled into the mainstream of society and provide them with independence and employment is urgently needed. Independence is a basic human right. In some cases adults are forced to remain in institutions because they do not have the necessary funding to acquire daily living technology that would enable them to reside at home or in their own apartments. Employment is also fundamental to human existence as we know it, yet the nonwhite disabled are victims of less than equal treatment. Citing the Current Population Survey (CPS) of 1981, Bowe reports that only 18.8% of black disabled males and 14.6% of black disabled females are employed. This creates a "Catch-22" situation for many minority individuals with disabilities for they cannot afford the technology that could lead to employment, which in turn would provide the money to pay for the technology.

Technology could become the great equalizer for all disabled people by providing them with an easier means to be educated, competitive in the job market, and endowed with dignity and independence. The economic advantages of such independence are considerable. Bowe (1980) estimates that every dollar spent for rehabilitation research returns $11.00 in cost benefit to society. Encouragement in this direction is forthcoming from major companies such as International Business Machines (IBM). IBM is funding research at the University of Michigan that will help stroke victims use the IBM PC to regain their reading and memory skills. IBM has also helped to initiate programs at 30 training centers where disabled individuals learn data processing skills. More than 1,500 have been trained and more than 80% have found jobs. Employment pos-

sibilities are also being explored in such programs as the technology work evaluation program (TWE) at Courage Center in Golden Valley, North Dakota. This program explores an individual's potential to enter computer programming training or pursue employment in the computer field. The blind are already experiencing expanded employment opportunities as programmers, input and credit verification operators, inventory controllers, word processors, reservation agents, and auditors. Visually impaired attorneys are assisted in their research by the Legal Talk Computer and state of the art electronic devices which enable them to access JURIS and WESTLAW databases (Bordley, 1984).

The section that follows focuses on various new assistive devices that are available for the disabled. They are discussed within the context of four areas of disability; visual impairments, mobility impairments, hearing and speech impairments, and impairments in cognitive functioning. Mentioning some devices by the product name under which they are marketed rather than by a generalized classification cannot be avoided. Often an assistive device is the only one of its kind and is not therefore embraced within a larger category.

VISUAL IMPAIRMENTS

Various magnifying instruments exist for the partially-sighted. Closed-circuit television reading devices are the most sophisticated technology in this category. Such products as the Viewscan Text System (VTS) can help the partially-sighted prepare typewritten manuscript. It comprises a large character screen for reviewing text before it is automatically printed out by an electric typewriter. A miniature hand-held scanning camera for reading printed text is included.

In the past, to access written or printed material, the blind have had to rely on sighted people reading to them, either directly or through the medium of a tape recorder. The Optacon (optical-to-tactile converter) is a tactile reading aid that attemps to remedy this situation. It is different from reading machines or talking terminals which it predates. It converts the image of a letter into an enlarged vibrating form that can be felt with one finger. Both print and handwriting can be read in this way (Lyons, 1984). Talking scales were the first device to emit voice output. They have been followed by talking calculators, talking clocks and watches, and talking thermometers. Other assistive gadgets for the blind include: a liquid level indicator which utilizes a sound source and is used when filling cups or flasks; the Mowat Sensor, a small hand-held device that uses high-frequency sound waves to warn of the proximity of objects; and a device marketed by the American Foundation for the Blind which identifies paper currency.

Paperless braille devices such as the Microbraille or the VersaBraille System act as braille word processors. An electronic keyboard with cassette storage provides braille writing, reading, editing, and display capabilities. When connected to an electric typewriter, paperless braillers can create typewritten manuscript from braille material, or, alternatively create braille copy from a typed text. The Viewscan, Microbrailler, and VersaBraille can be interfaced with computers and telecommunications devices.

The Kurzweil Reading Machine

The Kurzweil Reading Machine (KRM) provides the blind with direct access to printed or typewritten information by converting it into synthesized speech. The KRM, by virture of its optical character recognition, has the ability to read virtually any typeface. Material to be read is placed face down on the glass surface of the desk top scanning unit which automatically locates the first line and begins reading the text. The control unit provides adjustment to the volume, speech rate, and pitch of the electronic voice. The machine has the ability to spell out words that may be obscure, announce punctuation and capitalization, repeat previous lines, and "tag" certain words or phrases for later reference. The KRM can also be used to provide synthesized speech to a computer terminal or produce braille hardcopy when connected to a braille printer. Raymond Kurzweil's latest invention is a voice activated typewriter (VAT) that will prepare typed manuscript from verbal dictation.

Talking Terminals

There are various microcomputer accessories, most of them involving speech synthesizers, that enable blind persons to have

the same opportunity as sighted computer users. The Echo GP speech synthesizer for example, converts an Apple PC into a talking terminal. Word processing capabilities can be obtained by means of a speech device such as the Vert 6000 which can be set to verbalize each letter, word, sentence, or page that is typed. As a result blind students and professionals can type and edit their own papers and get copies in standard print or braille.

The Total Talk system from MCS is described as a complete computer workstation for the blind. It includes a personal computer, word processor, terminal, voice mail, and braille production system. Features of the Total Talk PC include a touch sensitive screen — it will speak the word that is touched on the screen; a speech pad which controls speech speed, pitch, pauses between words, and volume; an enunciator key which announces the chosen function; and a spelling checker which catches spelling mistakes. Total Talk can run many of the programs provided for standard personal computers.

MOBILITY IMPAIRMENTS

Input Devices

People with minimal keyboard ability have the benefit of various systems which reduce the number of keystrokes necessary to produce a message or a command. Many display a matrix on the screen from which the user makes a choice, normally by combining a column number with a row number. Keyboard masks can be fitted to accommodate uncontrolled hand movements.

Severely disabled individuals can control computer technology by a host of alternative input devices in place of the standard keyboard. In addition to the joystick, brow wrinkle switch, foot switch, and tongue switch, there are pointers that can be strapped to the hand or to the head, optical pointers that aim a beam of light, and pneumatic "sip-n-puff" straws that are blown and sucked. Wheelchairs that obey voice commands have been demonstrated and voice entry terminals for computers are becoming standard products. An eye-gaze keyboard is being developed by Sentient Systems. No special appliances are worn by the user who is able to activate one of the sixty keys by simply looking at the chosen key. One of the most sensitive input devices is the myoelectric interface which detects the minute electrical signals involved in the contraction of a muscle. It should be noted that many of the alternative input devices remain at the experimental stage and have yet to be fully tested by real-life applications over a prolonged period of time. In this regard Leifer (1983) offers some words of caution:

> While the human voice is capable of making thousands of utterances, only one or two can be machine recognized per second. The physiological signal channels (electromyogram and electroencephalogram) are conceptually elegant but unreliable. In the case of eye movement command/control, it is ... important to note that fatigue is usually proportional to the degree to which conscious attention is required in the control task.

Environmental Control Systems

A severely disabled individual is cut off from the direct control of his or her personal space and is unable to use the vast array of gadgets which most of us depend upon for our personal and vocational well-being. For individuals who are nearly totally paralyzed an environmental control system facilitates the operation of various electrical devices without assistance, thus promoting functional independence and improving the quality of life in the home, hospital, educational, or work setting. Such electrical devices include: automatic dialing telephone, television, fan, lights, intercom, radio, emergency alarm, and electric bed control. The control unit is operated from the bed, wheelchair, or work station. It is tailored to whatever functional movements an individual possesses. An environmental control system that utilizes a personal computer has been developed by the University of Alabama in Birmingham and is known as the C2E2 system (Communications, Control, Education, and Entertainment). The system is controlled by options selected from a control menu that appears on the computer's screen. In addition to operating the telephone and other appliances the user is able to take advantage of regular computer functions, such as typing letters and other documents, filing and retrieving information,

running educational and entertainment programs, and networking. The C2E2 is usually controlled by voice commands but will accept other kinds of input.

Robots

Personal robots will probably replace or interface with environmental control systems. An interactive robotic aid has one or more manipulators (arms) which can be moved within the environment to bring an end effector (hand) to any position within a prescribed space. Models for robotic manipulation devices have been developed by a number of agencies including John Hopkins University and the Veterans Administration New York Prosthetic Center.

In conjunction with the Palo Alto Veterans Administration Medical Center, Stanford University has developed a prototype robotic arm which is mounted on a console and operated by voice command. Although still in the research stage, this device can retrieve files from a drawer, turn pages in a book, draw and paint, pick up a telephone receiver, play board games, and prepare a meal. Researchers at Stanford are also exploring the potential as human helpers of such state of the art robots as the mobile, cannister-shaped RB5X.

The design philosophy of the "robotic aid" research community is that a disabled individual is best served by a single, general purpose system, rather than a collection of special purpose devices. By providing interactive command and control of manipulation in a relatively unstructured domestic environment, the researchers view the robot as an economically feasible partial substitute for human caretaking. Leifer (1983) suggests there are five primary applications where robotic aids will demonstrate superiority over other means for supporting independent living by persons with severe physical impairments:

1. ACTIVITIES OF DAILY LIVING: food preparation; food service; personal hygiene.
2. MEDICAL THERAPY: limited physical therapy; some forms of diagnostic testing.
3. PERSONAL CLERICAL TASKS: calculator and computer operation; use of commercial telecommunication devices; appliance control; office materials handling.
4. VOCATIONAL TASKS: supervision of industrial automation systems; computer and manipulator programming; assembly and inspection; secretarial work; switchboard operation.
5. RECREATION: control of environmental games; manipulation in physical games such as chess and monopoly; avocational work; painting.

HEARING AND SPEECH IMPAIRMENTS

Speech Analyzers

The non-speaking population includes individuals who are deaf and those with various kinds of communication disorders. These impairments deprive individuals of the joys of communication. Often non-speaking persons are believed to be uneducable only because they cannot express what they know. Various devices for the hearing impaired or those with vocal disorders can provide visual displays of the spoken word and can assist in the formation of intelligible speech. By means of a Speech Spectographic Display (SSD) words spoken into a microphone are translated into a broadband spectogram on a television screen. A student practices sounds and words by matching the pitch, tone, intensity, and duration of utterances to model patterns created by an instructor who enunciates the word correctly. Thus individuals who have never heard themselves talk can improve speaking skills by literally seeing what they say. This technology is very necessary in light of the fact that the majority of profoundly deaf children finish their education without intelligible speech (Jensema, et al., 1978). Studies have shown that independent drill with speech display creates better vocal production and increases motivation. Visual speech displays are useful to speech clinics, schools for the deaf, special education departments, rehabilitation programs, etc. Considerable gains in time and cost effectiveness have been demonstrated as a result of the utilization of speech analyzers in training (Houde and Braeges, 1979). The Video Voice Training System includes an SSD, computer hardware and software, television receiver, and various instructional materials.

TDDs

In recent years telecommunications devices for the deaf (TDDs) have enabled the deaf and hearing impaired to communicate over telephone lines using the printed word. The spread of personal computers has furthered the ability to transmit information using telephone lines and a number of computer networks have come into existence. The Baudot encoding system of a teletypewriter (TTY) is not compatible with the ASCII system used by a computer, but modifications are now available that enable a PC user to communicate with both Baudot and ASCII devices. Some of the modern TDDs such as Audiobionics' Lifestyle Personal Communicator are able to utilize both encoding systems. This portable device includes features such as a programmable memory, speech synthesizer, message capability, alarm, and word-processing functions.

Computer Networks

Computer networks provide two-way communication possibilities (e.g. electronic mail) and access to various kinds of information. For the hearing impaired, networking provides the opportunity to communicate interactively in a situation of equality. Deaf children in particular, can benefit from practicing language in a real world situation in which their disability does not create an ongoing disadvantage. Networks currently in existence include The Source, CompuServe, and Special Net. Other experimental networks such as Deafnet, focus on special needs groups and are operated by such institutions as NARIC and Gallaudet College in Washington, D.C. (NARIC, 1984). CompuServe offers services for handicapped computer users and in the future will include public information from the Social Security Administration. Special Net provides the disabled with bulletin board services and includes special services such as ASHA Update, NARIC Report, Deafness, Vision, and NCAH News. Not limited to bulletin board or electronic mail functions, networks such as Game Store provide the opportunity for recreational activities.

Augmentative Communication Aids

Various assistive technologies are now available that provide augmentative communication to this population. A battery-operated pocket typewriter that prints on a paper roll is an inexpensive device that can provide rudimentary communication to non-speaking individuals. Many people who are severely physically handicapped, however, cannot write or use a conventional keyboard. Current technology can utilize an individual's limited movements to operate devices that express needs or ideas. The Handi-Writer is such a communication aid. By closing a single switch (e.g. footswitch, eyebrow microswitch, sip-n-puff straw) the user can construct words and sentences on an ordinary television screen. In addition, the text may be printed out on a printer or "spoken" through the television using an optional voice synthesizer (Bulletins on Science and Technology for the Handicapped, 1984). A synthesized speech system which operates through a highly modified pair of glasses has been developed by the University of Denver's Research Institute. A tiny chart with letters is located in front of one lens. By steadying one's gaze in precise spots the user can spell out what is desired. An electronic voice recites the letters as they are printed out across a small screen and the messages are printed out on paper.

Portable microprocessor-based aids housed in a wheelchair laptray configuration can provide non-speaking persons with the ability to hold conversations, speak on the phone, shop for items, and order meals in restaurants. Such communication systems are operated by a matrix keyboard and normally allow the option of a printed message or synthesized speech output. In addition, to pre-programmed words and phrases, a storage area allows personal information to be programmed by the user for retrieval by a single selection. The VOIS 130 manufactured by Phonic Ear is such a system as are EXPRESS 3, Autocom, and MINSPEAK 1 from Prentich Romich Company. The Autocom is designed to accommodate erratic movements from individuals with severe cerebral palsy and can be operated by a magnetic handpiece or alternatively a headstick. MINSPEAK 1 can be operated by any severely handicapped individual who has a reliable body movement. A degree of naturalness can be obtained from the synthesized speech because the user can emphasize or de-emphasize a word by controlling the pitch or duration of individual phonemes. By this means, a question can be

made to sound like a question. When fitted with a keyboard emulator many electronic communication aids can serve as a data entry terminal for a computer and also interface with an environmental control system.

IMPAIRMENTS IN COGNITIVE FUNCTIONING

The human brain is an instrument designed to deal with real-world situations, therefore, many of the devices described in the previous sections enhance cognitive functioning to some extent because they improve an individual's interaction with the environment. Because the computer is essentially a manifestation of human rationality it is an ideal vehicle for promoting reasoning skills. Bowe (1984) states that "some of the most dramatic applications of microcomputers occur with children, youth, adults, and older individuals with various kinds of mental limitations." Computer applications for special-needs students are beneficial because the game-like quality of many interactive programs helps keep the participants motivated. The dynamic presentation utilizing color animation and speech synthesizers foster an increased attention span. The immediate and nonjudgmental feedback promotes learning. Success in using the computer is reinforcing also as it fosters a sense of accomplishment and pride.

Maplewood Handicapped Children's Center in Edmonds School District, Washington, has designed over a dozen training programs to develop both motor and cognitive skills of severely physically handicapped, non-vocal students. Since the children are not verbally-oriented the programs use color, sound, and graphics. A remedial and diagnostic program for learning-disabled students has been designed at Robert E. Lee High School in San Antonio, Texas. The program aims to develop memory, concentration, reading, spelling, and vocabulary skills. "Because of the program's game-like format, structured contents, and immediate reinforcement for correct responses, learning-disabled students with attention spans as short as three minutes were able to demonstrate academic growth comparable to that of their able-bodied peers while using the program" (Bowe, 1984). The North Shore Children's Hospital in Salem, Massachusetts has also developed computer programs to help learning disabled children.

LOGO, the turtle-based programming language is successful with many special-needs individuals. Because it requires very little language it has proven to be effective with people whose mastery of the language is restricted. Research at Texas Technological University has demonstrated that LOGO offers a unique way to teach abstract concepts to learning-disabled and retarded individuals who are having difficulty grasping nonconcrete ideas. MCE, Inc. recently announced the release of special education software named "The Lost R—Reasoning" which is designed for special-needs students and provides instruction and practice in the use of reasoning skills. Programs have also been developed to help stroke or head-injury patients to recover visual perception and memory skills. Bowe (1984) informs us that the Atari "Hangman Game" and the "Brain Game" are found to be useful at the Brain Injury Rehabilitation Unit of the Veterans Administration Medical Center at Palo Alto, California. The unit serves veterans with brain conditions resulting from accidents, strokes, brain tumors, and degenerative diseases.

COSTS

There is no doubt that technology can expand the horizons of the nonwhite disabled. Yet, many factors render the production of assistive devices a precarious industry: the novelty of the technologies, the high costs, lack of prolonged testing, and inadequate attention to consumer education. Irrespective of their social benefits, technologies often compete according to economic criteria whereby profitability determines which technology is developed. Mass production can keep down the cost of items that have substantial markets, such as a device that is useful to a large number of blind people. The cost of small assistive gadgets for the blind such as talking watches or thermometers range from $30 to $100, while professional programmable calculators with print and braille output can cost over $1,000. As a microcomputer accessory, speech synthesizers start around $300. In contrast the Total Talk PC costs $7,995, the Versa Braille word processor costs about

$7,000, and the Kurzweil Reading Machine costs $30,000.

Much of the computer technology available for the handicapped today is so expensive that it is generally purchased by employers, vocational rehabilitation programs, or educational institutions. A representative of one firm that sells microcomputer equipment for the visually impaired estimates that only 5% to 10% of that company's sales are for home usage. Unlike reading machines or braille word processors, augmentative communication aids for non-vocal individuals do not easily accommodate shared usage and do not therefore represent a viable institutional purchase. For an individual they represent a considerable expense. The Handi-Writer is one of the most economical communication aids and ranges from $400 to $800 according to the number of options available. Portable speech synthesizers are more expensive. The VOIS 130 costs $3,000, the EXPRESS 3 with optional speech included costs $4,900, and the MINSPEAK 1 retails at $5,990. The Video Voice Speech Training System is marketed for use in speech clinics and at $3,250 is relatively inexpensive. Audiobionics' Lifestyle Personal Communicator which combines TDD capabilities with a speech synthesizer is priced at $1,759. It is worth noting that all federal agencies are required by law to provide equipment and services that handicapped employees need to do their jobs.

The price of environmental control systems varies according to the number of options and the types of electrical devices that are operated. The expense of independent living devices may well be offset by savings experienced due to a decrease in human caretaking. Leifer (1983) anticipates that a robotic aid for a severely disabled individual represents feasible partial substitute for 24-hour attendant care. He states: "While it is premature to make definitive statements regarding Robotic Aid economics . . . one may speculate that a widely available robotic manipulation aid would cost about as much as a personal automobile and come in an equivalent variety of models."

Funding Sources

Funding for assistive technology can come from a variety of sources. Government programs that have provided funds for assistive devices include Medicaid; Medicare (which has not to date funded electric communication aids); Offices of Vocational Rehabilitation; Veterans Administration; Developmentally Disabled Programs; programs which are known alternatively as Bureau of Medical Rehabilitation, Crippled Children Services, or Physically Handicapped Program; Committees on the Handicapped formed to comply with PL 94-142; government employers affected by PL 95-602; and complementary minority programs such as those for the blind, deaf, mentally retarded, mentally restored, psychiatrically handicapped, and aged. Voluntary health organizations that are potential funding sources include the United Cerebral Palsy Association Easter Seal Society, National Multiple Sclerosis Society, Muscular Dystrophy Association, National ALS Foundation, ALS Society of America, and United Fund-sponsored programs. In addition, the social services allocate funds for vocational rehabilitation and developmental disabilities programs; health services authorize expenditures for medical, surgical, and corrective care for individuals with limited means; and education agencies undertake to meet the specialized needs of disabled children and emphasize services for the severely handicapped. There are alternatives to the outright purchase of assistive devices. Various voluntary organizations and medical facilities support loan equipment pools. Some even try to give devices to individuals who qualify for an authorized program. A few manufacturers provide equipment for extended trial periods, while others have leasing programs by which a device can be purchased over a period of time.

Because many assistive devices represent a new and unfamiliar technology, ignorance of their potential application results in administrative blind spots. For example, while most bureaucrats would agree that a wheelchair is essential to a paraplegic, few are prepared to admit that an expressive communication aid is equally necessary for a non-speaking person. An individual who is severely disabled as a result of the catastrophic effects of an illness or injury may well encounter this problem of shortsighted attitudes with an insurance company and find that they balk at covering the cost of an assistive device. Insurance companies often avoid coverage of an electronic communi-

cations aid by classifying it as an "educational" rather than a "medical" device. It is even more difficult to obtain reimbursement for daily living systems for the severely physically disabled for they do not represent a clear medical, vocational, or educational expense. The critical ethical issues that problems of classification of devices raises clearly demonstrates the need for enlightened debate in order to effect a change in administrative attitudes towards the new assistive technologies.

Advocacy and Consumer Education

If attempts to acquire funds for assistive devices through conventional funding sources are unsuccesful, then more creative strategies can be brought to bear on the situation. Ruggles (1982) outlines a four-step procedure for securing funds. The first step is self-evaluation; the second step is expanding information resources; the third step is advocacy; and the fourth step is exploring funding sources and strategies. Ruggles emphasizes that the client's family should be included in the advocacy process. Additionally, an expressed willingness on the part of the client and his family to provide a portion of the purchase price helps create a favorable impression for subsequent endeavors. Various committees and coalitions that have the knowledge and experience to be effective advocates can be contacted. Ruggles recommends an examination of plans for spending block grant monies. He also recommends that legislators, program administrators, and school board members are solicited for support during informational visits, and letter writing and phone campaigns. Various service and church-affiliated organizations are often ready to help handicapped individuals secure their needs. By utilizing creative strategies, funds might be forthcoming from employers, labor unions, major corporations, and workman's compensation programs. One strategy often used by whites is to mount a media campaign and call for sponsors around a deserving individual who has obtained a device on a temporary basis by loan or for a limited trial period. Public awareness can also be heightened through special fund-raising events. Certain civic or community organizations are often ready to assist in the sponsoring of fund-raising drives. Ruggles suggests that creative funding strategies should include the possibility of matching or combining donations acquired from different sources in order to reach the total amount required.

Problems of high prices of the innovative but unfamiliar technologies and the financial instability of the disabled as a consumer group are compounded by unenlightened administrative attitudes. This results in a general under-utilization of assistive devices. There must be a greater degree of human interface and trilateral cooperation between nonwhite individuals with disabilities, the service organizations which represent the disabled, and the manufacturers of assistive technology. Such a partnership could enlighten attitudes concerning the new devices and highlight issues of cost, availability, and equity of access. More attention to consumer education is also urgently needed. It is currently too slow, too happenstance, and too dependent on ethnicity, socio-economic status, sex, and age. There is also a need for constant communication between the designers of assistive technology and the nonwhite consumer. As Leifer (1983) states 'It is imperative that technical people establish and maintain a constructively critical dialogue with prospective users of their product.' As a result of these measures it can be anticipated that more nonwhite individuals with disabilities would learn to define and articulate their own needs more clearly and become involved with the process of self-advocacy.

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SECTION V
Preparation of Professionals and Career Development for the Disabled

15 • A College-Based Rehabilitation Training Program for Working with the Nonwhite Disabled

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Abstract

This article describes a college-based rehabilitation training program for counselors preparing to work with nonwhite disabled clients. The training program outlined in this article consists of the following components: 1) sensitivity training, 2) communication skills (verbal and nonverbal), 3) multicultural awareness (especially cultural awareness related to nonwhite population, 4) techniques of self-disclosure, 5) client-counselor relationships, 6) creative strategies of pre-vocational and vocational activities, and 7) techniques and resources of support systems and value systems for the nonwhite population. The author emphasizes the importance of developing such a rehabilitation training program for counselors working with nonwhite clients because of the unique "special needs" of this population.

Program, curricular, and preparation areas most in need of review in meeting the unique needs of the nonwhite disabled are counseling techniques, placement and community resources, and client assessment. In this paper, emphasis will be placed on counseling skills and functions.

COUNSELING TECHNIQUES

Rehabilitation counselors need sensitivity training in the cultural, racial, and life style differences of nonwhites. Communication is the nucleus of the counseling process; therefore, counselors must be aware of dialectical variations in the English language. Misunderstood variances and idioms give rise to misinterpretation and inhibit the close working relationships essential in client-counselor relationships. Counselors are taught to neither condemn nor condone, but seek to understand that which a client is saying on verbal and nonverbal levels.

Training counselors to work with the nonwhite disabled involves other special issues: (1) client reluctance in selfdisclosure, (2) a value system peculiar to the background of the client, (3) a pattern of non-adherence to time schedules, (4) lack of eye contact, (5) disappointment with the cognitive-verbal process of counseling instead of action-oriented help, (6) lack of strategies and tech-

niques for dealing with an oppressive environment and, (7) inadequate self images and self concepts. Most of these issues can be developed into training modules.

Rehabilitation counselor training programs must provide for multicultural awareness and special knowledge of the black experience because statistics reveal that blacks represent a larger proportion of the disabled population than any other ethnic group. Recent data reveals that 13.4% of the black population have work related disabilities, 8.4% of the white population have such disabilities, and 8% of the Hispanic population is disabled. Seminars and workshops on the black experience must be provided just as are seminars on independent living and client assessment.

Adherence to principles and concepts of good human relations are essential for successful closure in the vocational rehabilitation process as it relates to nonwhites. Counselors must examine their prejudices before working with clients. They must forego rigidities and utilize maximum flexibility in finding solutions to problems. Counselors must also actively explain tests and client understanding of what vocational rehabilitation can and does offer. Counselors must be trained as activists within the nonwhite community and be accepted and viewed as true ombudsmen and advocates.

It is further recommended that counselors teach clients a long-range point of view about the rehabilitation process and its rewards. Counselors are expected to find a way of moving nonwhite clients more rapidly into and through various nonrewarding aspects of rehabilitation programs. Counselors (in training) also must be taught concepts as well as techniques which help clients become aware of the benefit of rehabilitation earlier in the sequence. (Such rewards for clients include greater independence and the ability to earn higher income.) This recommendation is made in order to reinforce the client's motivation for continuance in the program. Finding viable rewards for nonwhites is not an easy task. Competition from high reward systems is keen. Nonwhite clients can often earn higher incomes from illicit activities than they can gain through rehabilitation programs.

Client goals must be clearly defined. Participants must know where they are going, the manner in which they will get there, and the time they can expect to arrive. Counseling and reinforcement are critical at each stage along the rehabilitation continuum. Vague, ill-defined goals will result in dropouts. Nonwhites need to be assured that the program is not another dead end that satisfies the providers and has few, if any, benefits for the participant.

White and black counselors who serve black clients should gather within the agency a collection of literature about black history and culture. It is important to note that black counselors can be dangerous to black clients if they have rejected their own culture in their struggle for advancement in the profession.

It is important that rehabilitation counselors (both white and nonwhite) become aware of the ways in which their behavior effects their clients. Such behavior may include overt racism and hostility, covert prejudice, and cultural ignorance.

Several factors are involved in the forces at play in establishing the black self concept and conscious identity. Some conscious identity factors are: "How I see myself," 'How I see myself in relation to others," "How others see me," "How I see myself as a black person" and "How I see whites."

PLACEMENT AND COMMUNITY RESOURCES

Counselors must be taught creative strategies in providing pre-vocational activities as well as finding appropriate job placement sites. It is also essential that counselors provide clients with continued support and follow-up after job placement. Therefore, placement training must be complemented with a thorough knowledge of rehabilitation legislation and the legal rights of the handicapped.

Effective rehabilitation training programs must also equip trainees with skills in public relations. Rehabilitation counselors must develop ties with a wide array of community organizations including affiliation with the white business and industrial sectors as well as the total institutional and social system.

Affiliation with support systems in the nonwhite community is also paramount. Organizations should include fraternities and sororities, civic organizations, social clubs, political organizations, professional associations, and the church.

CLIENT ASSESSMENT

In the process of psychological evaluation, it is important for the counselor to know the nonwhite's attitude about testing. The counselor must not view the attitude toward testing as a lack of motivation. The following guidelines and principles should be adhered to in psychological evaluation: (1) provide the client with an orientation to psychological testing, (2) administer the easiest test first, (3) limit the testing time, (4) administer tests individually to allow for adaptation, (5) provide for the re-administration of a similar test or alternate forms, (6) in explaining test results to the client, emphasize positive aspects and use nontechnical language in the interpretation of tests, (7) use work samples in lieu of regular psychological tests, (8) use commercial work samples that are oriented to nonwhites, (9) use caution in recommending nonwhites for stereotyped jobs such as sanitary engineers, porters, food service workers, (10) use role models in occupational exploration, and (11) discuss occupational hazards with the client.

CONCLUSIONS

The counselor must develop a commitment to the value of the human being and assess the potential, worth, and assets of each client. Counselors must gain competency, skill, and creativity in understanding the motivational system of clients and foster a mechanism that provides intermittent and recurring reinforcement for this system on a short range basis. Effective counselors must develop a desire to help nonwhite clients and make a commitment to do so. Counselors must show that they care, but they must not promote dependency and treat the client in a condescending manner. Furthermore, the counselor must work against any dehumanizing procedures within the rehabilitation system.

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16 • A Model for Training Speech-Language Pathologists to Meet the Unique Needs of Minority Individuals

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Abstract

The focus of this article is the development of a model for training speech-language pathologists at the graduate level to meet the unique needs of minority individuals. The proposed model contains the necessary course-work requirements for speech-language pathologists to work with general populations as well as minority individuals in terms of clinical and leadership level training. Clinical training consists of the following components: (1) knowledge of a) the principles and methods of service delivery for the general and non-white population, and b) of the cultural and linguistic differences of the non-white population; (2) skills, competencies, and knowledge required by ASHA masters level training are also included in the program sequence. Leadership training is offered at both the doctoral and post-doctoral levels. The leadership training consists of the following components: (1) current theoretical and research issues of leadership needs in the field of speech-language pathologists, (2) in-depth knowledge of issues and practices related to cultural/linguistic diversity and communication disorders, (3) knowledge of leadership skills, and (4) research needs related to cultural/linguistic diversity and communication disorders. The author also gives a comprehensive illustration of each level of the training model.

In 1981, the National Center for Health Statistics estimated that 20 million Americans—approximately 10% of the population—suffered from communication disorders. Further, Fein (1983) projected that between the years 1980 and 2050, the number of persons with speech and hearing impairments will increase at faster rates than the total population.

Perhaps more striking than the incidence of speech, language, and hearing problems in the general population, is the fact that research on the incidence of these disorders among some minority populations, i.e. blacks, has revealed figures as high as 19.8% (Fay et al, 1970). Although admittedly, this figure may be distorted because diagnostic instruments fail to reflect sensitivity to cultural and dialectal differences, there is little doubt that high incidence rates for communication disorders among persons from low income and minority populations are related, in part, to poor health status, inaccessibility to and unavailability of health care services, and social and environmental factors.

Based on these factors, if the same projections for increases of communication disorders within the general population are applied to low-income and minority groups, it is reasonable to postulate that in the next several decades, there will be great need for speech-language pathologists who have knowledge and skills to provide services to communicatively handicapped individuals in these populations. A nationwide survey conducted by The American Speech-Language-Hearing Association (ASHA) in 1985, revealed that 74% of the certified speech-language pathologists reported that they worked with clients from minority populations on a frequent basis. However, of those surveyed, 77% felt that they were not highly competent to serve these populations. When asked where they received their training to work with minority populations, only 13% stated that they were taught during their academic or practicum training. The remainder of the surveyed population provided no indication of training or compe-

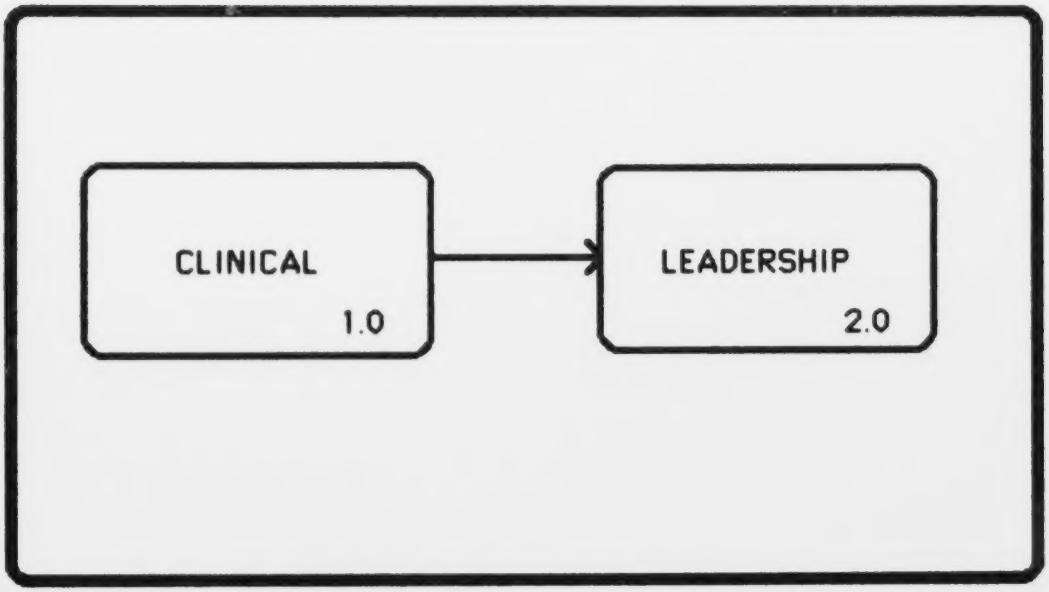
tence relative to the needs of nonwhite speech impaired persons. Further, Cole (1983) reported that in an informal review of recent applications for the Certificate of Clinical Competence, only 2 in 20 applications—10%—had taken a course in sociolinguistics.

Because ASHA establishes no specific course requirements for clinical programs in regard to social dialects, few institutions offer such courses. Indeed, it may be observed that there is a dearth of faculty with background and training to provide instruction pertaining to linguistic and cultural diversity or to conduct research to develop current theory and practice concerning the needs of these populations. Taking these factors into account, it can be argued that there is currently, and will continue to be, a shortage of speech-language pathologists with the necessary skills and competencies needed to deliver effective clinical services to minority individuals.

The purpose of this paper is to present a model for graduate training in cultural/linguistic diversity and communication disorders which responds to these current and projected needs. The model described focuses upon the provision of effective services to the general population as well as linguistic and cultural minority groups. The terms "linguistic diversity" and "cultural diversity" refer to the notion that every person is a speaker of some language variation which reflects one's social heritage. These variations of language are known as dialects. Standard English is one such dialect. The concept of cultural/linguistic diversity recognizes that although standard English is the preferred dialect within this culture and is spoken by the privileged classes, other dialects are also important and valuable in that these dialects communicate the needs, desires, and emotions of their speakers. Therefore, all variations of language are afforded equal recognition.

A training program in cultural/linguistic diversity and communication disorders must provide the usual kinds of information relative to speech, language, and hearing disorders in the general population, with an additional focus upon the nature, diagnosis, and remediation of communication disorders in other linguistic and cultural groups within the society. The present model for graduate training in cultural/linguistic diversity and communication disorders contains two components as identified below.

LEVEL 1



Both components of the graduate training program are based on the following set of premises:

(a) Provision of services to communicatively handicapped individuals in culturally and linguistically diverse populations must be based on a firm knowledge of the principles and methods of service delivery for the general population, as well as an understanding and respect for the differences of other linguistic systems and cultures.
(b) Development of skills and competencies for the provision of services to linguistically and culturally diverse populations requires specific academic and clinical training conducted by professionals who are knowledgeable in these areas.

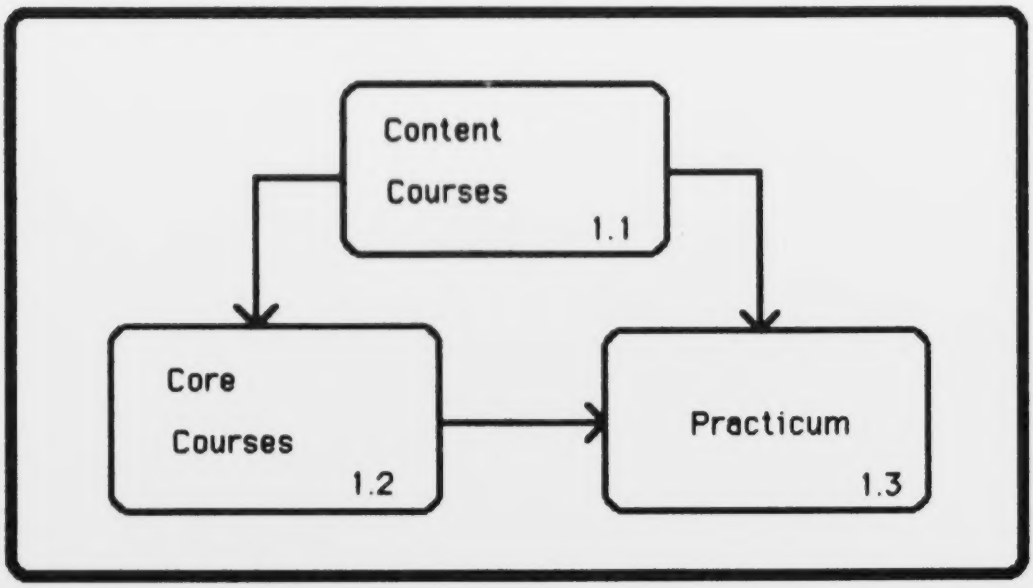
The clinical component describes training at the masters level. As required for the Certificate of Clinical Competence from ASHA, masters level training entails specialized coursework, as well as supervised clinical practicum in all disorder categories. There are three interrelated sub-components of masters training including content courses, core courses, and practicum.

Content courses provide students with knowledge of both normal communication development and disorders. Wherever appropriate, content of these courses include specific segments on topics relative to social dialects and various cultural groups in addition to the usual content of information for the course. For example, health, educational, social and environmental factors that relate to causes, diagnosis, as well as prevalence and treatment of communication disorders in various populations are discussed. Exceptions to this practice hold for coursework such as anatomy and physiology and speech science. Students also complete a prerequisite course in dialectology which is designed to introduce them to linguistic concepts related to social dialects.

Two specific content courses provide comprehensive, in-depth knowledge of cultural/linguistic diversity and communication disorders. A general course in sociolinguistics introduces students to language

LEVEL 2

1.0 CLINICAL COMPONENT



variation and its relationship to social factors. This course is a prerequisite for a more advanced course in sociolinguistics which presents information relative to the application of sociolinguistic theory to clinical, educational, and societal problems.

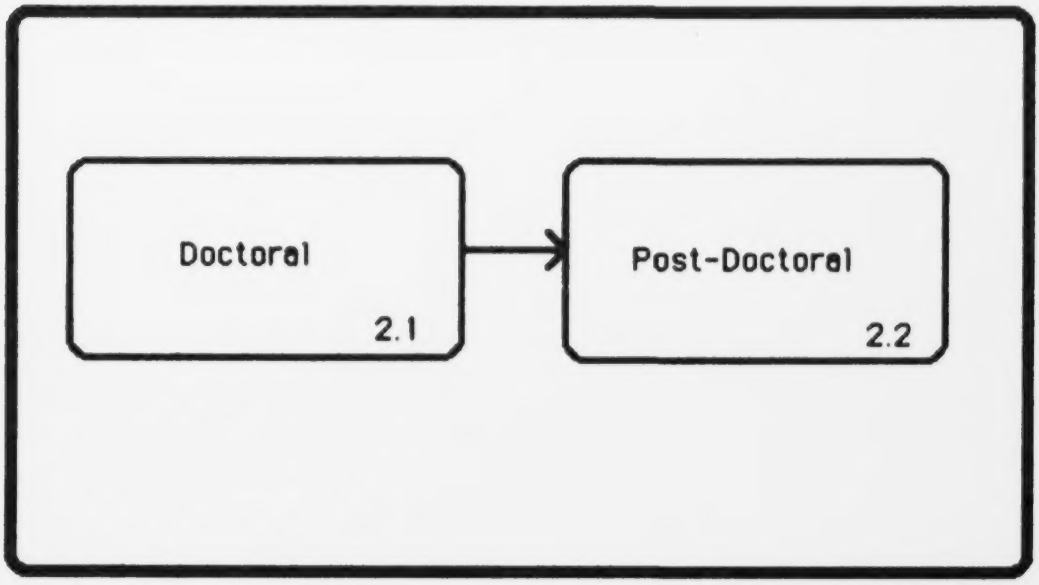
Core courses involving statistics, research techniques, and thesis execution prepare students to conduct culturally valid research specific to one minority population or applicable to linguistically or culturally diverse populations. In addition, students learn to critique research from the perspective of culturally and linguistically diverse populations.

Clinical practicum is a crucial aspect of the masters training program in cultural/linguistic diversity and communication disorders. The requirement of clinical practicum is that students not only gain experience with the various age groups and disorder types, but that they also gain clock-hours in diagnosis and treatment of clients from culturally and linguistically diverse populations and various socio-economic classes. Students conduct clinical activities within the multi-cultural university community, as well as inner-city day care centers where they gain experience in differentiating between social dialects and true communication disorders. Students also learn to identify and modify linguistically or culturally biased diagnostic instruments and to adapt therapy materials to the needs of these populations.

The leadership component of the present model for graduate training in cultural/linguistic diversity and communication disorders contains two subcomponents as indicated below. The doctoral training program responds to future leadership needs within the profession, while the postdoctoral program responds to the immediate need for researchers, academicians, and administrators to serve communicatively handicapped individuals in linguistically and culturally diverse populations.

LEVEL 2

2.0 LEADERSHIP COMPONENT



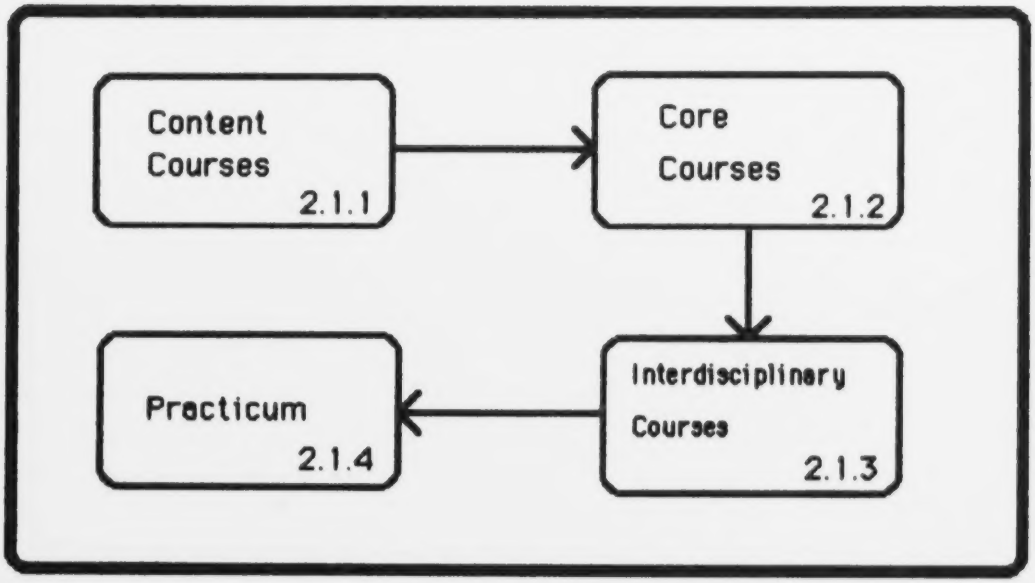
Doctoral training is sufficiently comprehensive to provide students with advanced training in matters pertaining to the execution of administrative, academic, clinical, and research activities for communicatively handicapped individuals in the general population, as well as in other linguistic and cultural groups. There are four elements of the doctoral program including content courses, core courses, specialization seminars, and practicum. Students enroll in 28 semester-hours of content courses within the department. These courses provide current information on normal and pathological communication focusing on theoretical and research issues rather than clinical procedures. Wherever appropriate, content courses contain segments related to these factors regarding research, theoretical issues, etiology, diagnosis, and therapy in communication disorders. Students are directed to specific readings and trained to critique research from the perspective of cultural and linguistic diversity.

Two content courses address the general topic of cultural and linguistic diversity. Specific seminars in cultural/linguistic diversity and communication disorders, and bilingual/bidialectal education provide students with in-depth knowledge of issues and current practices. In addition, independent studies are offered to students who wish to gain further knowledge on any specific topic of interest.

In addition to the information presented in content courses, all doctoral students are required to have knowledge of research design and methodology, program design and evaluation, and topics in social and cultural dimensions of human communication. This knowledge is imparted through core courses. Core courses prepare students for the kinds of leadership positions they will assume upon completion of the program. In these courses, attention is given to understanding and developing culturally and linguistically valid research methodologies for culturally diverse populations. Students are

LEVEL 3

2.1 DOCTORAL PROGRAM



encouraged to develop original research that will contribute to the body of knowledge of communication disorders in these populations.

Doctoral students are also required to enroll in at least two interdisciplinary courses outside the department. Advanced coursework may be taken in related disciplines such as medicine, dentistry, allied health, child development, linguistics, health care administration, intercultural communication, social work, psychology, anthropology, and education. The interdisciplinary feature is designed to buttress students' knowledge in their career specialization area. For students who wish to gain further knowledge in cultural and linguistic diversity, interdisciplinary courses may be taken in linguistics, anthropology, social work, or intercultural communication.

While practicum training is crucial to most masters programs, few doctoral programs require such activity. In order to further develop leadership skills, doctoral students participate in a unique and innovative practicum experience known as apprenticeships. These 20-hours per week work/learning experiences are designed to give students real-life experience in a variety of settings and responsibilities in administrative, academic, research, and clinical functions. Apprenticeships represent the spectrum of potential employment settings and professional responsibilities. Most apprenticeships are performed outside the department and the university community under the preceptorship of trained leadership personnel within the profession. All apprenticeships provide students with exposure and experience in providing services to culturally and linguistically diverse populations. One such site is the ASHA Office of Minority Concerns.

The postdoctoral component addresses the immediate need for qualified instructors to train future speech-language pathologists to provide clinical services to linguistically and culturally diverse populations. Postdoctoral training is specifically structured to expose fellowship recipients to a full range of information, data sources, research methodologies, and senior academicians and researchers in sociolinguistics and communication disorders so that they, in turn, may generate new approaches to the delivery of speech and hearing services to culturally and linguistically diverse populations. Designed specifically for academic personnel, the primary objective of the postdoctoral program is to produce effective leadership by focusing on research and publication, curriculum design, academic training, teaching, and clinical experiences. The objectives of this program are to enable each recipient to: (1) design and implement a college curriculum in communication disorders which specifically focuses on the issues and needs of linguistically and culturally diverse populations, (2) contribute to the current body of knowledge and research relative to communication disorders in linguistically and culturally diverse populations, and (3) train pre-service personnel to deliver effective clinical services to linguistically and culturally diverse populations.

The postdoctoral fellow serves a 9 to 10 month tenure within the department and audits courses on cultural/linguistic diversity, communication disorders, and other courses of interest. The fellowship recipient also surveys the current literature in sociology, anthropology, linguistics, medicine, education, and psychology relative to linguistic and cultural issues in language development and communication disorders. The postdoctoral fellowship recipient also designs and conducts research under the guidance of senior faculty within the department. Finally, the fellowship recipient designs a full graduate training curriculum similar to the present model, including courses, discussion topics, reading lists, textbooks and practicum skills for each disorder category with specific focus on cultural and linguistic diversity. In conjunction with this activity, the fellowship recipient may provide guest lectures on the segment within masters or doctoral courses which deals with cultural and linguistic diversity. The postdoctoral fellowship recipient may also elect to gain clinical experience through the campus speech and hearing clinic.

Training in cultural/linguistic diversity and communication disorders extends beyond the university curriculum. The department offers an extensive continuing education program, an annual student conference, a biennial international interdisciplinary conference, and supports a number of profes-

sional organizations such as the National Black Association for Speech, Language, and Hearing.

An essential part of any training program is the presence of effective role models for students. The faculty includes individuals with national and international reputations. The faculty itself is multi-racial, multi-cultural, and international. Two linguists, including one sociolinguist, are faculty members. Two professors of communication disorders possess strong linguistic and sociolinguistic backgrounds. Several are fluent in foreign languages and are knowledgeable about issues related to bilingualism. All faculty and instructional staff have had academic and/or clinical experience in cultural/linguistic diversity and communication disorders.

The implementation of an effective graduate training program in cultural/linguistic diversity and communication disorders requires commitment to the development of relevant skills and competencies by its trainees. The model described above is committed to this goal.

Establishment of the present model or similar models toward the same goal will ensure that future generations of speech pathologists will have the training necessary to ameliorate the clinical needs of the populations of mankind.

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17 • Providing Access for Nonwhite Disabled Students to Community College Programs

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Abstract

The Center for Disabled Student Services of Chicago City-Wide College has developed a model for students to explore career options, obtain support services, and enter programs of City Colleges of Chicago. The Chicago City-Wide College develops and implements programs and special services for students who are disabled, disadvantaged, or limited in English language proficiency. The Center for Disabled Student Services' model for service delivery involves recruitment, intake assessment, orientation, referral services, and direct services through various units. The functions of the various units of the Center for Disabled Student Services are discussed.

Community college programs provide excellent education and training opportunities for many individuals. As enrollments of special needs individuals increase, services and specialized programs must reflect the additional demands of a diverse student body. The Center for Disabled Student Services of Chicago City-Wide College has developed a model by which entering students are given the opportunity to explore career options, obtain individualized support services, and enter appropriate programs of the City Colleges of Chicago.

THE CITY COLLEGES OF CHICAGO

The City Colleges of Chicago form a cohesive network of nine urban-based community colleges operating under an open admissions policy. Under the guidance of a Board of Trustees, each campus of the system develops programs and policies to reflect and effectively serve the unique communities in which they are located. Seven of the colleges—Daley, Kennedy-King, Loop, Malcolm X, Olive-Harvey, Truman, and Wright Colleges—offer comprehensive, traditional educational, and vocational programs.

There are two non-traditional campuses in the City Colleges of Chicago. The Chicago Urban Skills Institute provides Adult Basic Education, English as a Second Language, General Educational Development (GED) preparation classes, and vocationally oriented trades to prepare students for entry-level employment. The other non-traditional campus is Chicago City-Wide College. Established in 1974 as a "college without walls," its directive is to develop and implement programs and specialized services for segments of the community which are either underserved or not traditionally served by institutions of post-secondary education. These include students who are disadvantaged, disabled, and limited in English proficiency. Both traditional and non-traditional programs are developed, coordinated, and administered by Chicago City-Wide College in cooperation with other campuses in the system and with community-based agencies. These programs include classes in the work place, prisons, and institutions, as well as programs serving military personnel throughout the world. In an effort to serve students who cannot attend on-campus classes on a regular basis, the College offers instruction by a video cassette at local library branches and via radio and television on the City Colleges' own TV station.

One of the hallmarks of the City Colleges of Chicago is the willingness to serve diverse groups of individuals who wish to enroll and compete in programs. In 1972, the Colleges recognized the need to integrate disabled students and began to conduct planning conferences, obtain community input and support, and identify sources of funding. In 1975, the Center for Disabled Student Services within the Chicago City-Wide College was formed to insure programmatic accessibility to disabled students and to oversee the integration of these students into the City Colleges of Chicago.

THE CENTER FOR DISABLED STUDENT SERVICES

The challenge of meeting the individualized needs of special groups involves careful planning and implementation. In an era of diminishing financial resources and an increasing awareness of the needs of divergent populations, program effectiveness relies upon cost-effective, non-duplicative service delivery. To this end, the Center for Disabled Student Services has developed a flexible and comprehensive model for delivering services to students. The model contains several interactive components: recruitment, intake assessment, orientation, referral services, and direct services. All are intended to insure that resources of the City Colleges of Chicago are accessible to students with special needs. The successful utilization of the services ultimately depends on the student. Although the Center understands that there are realities (at times difficult realities) associated with being disabled, it also encourages students to accept the idea that their circumstances need not prevent them from achieving their goals, that their ability to succeed lies within themselves. This recognition is reflected in the philosophy of the Center which is to provide disabled students with the skills and strategies necessary to become as independent and self-sufficient as possible in order to compete effectively, not only in an educational setting, but in the work world.

Each student entering the City Colleges of Chicago is unique. Some have multiple special needs. The task of identifying stu-

dents, determining their individual needs and goals, and providing appropriate services is challenging. To ensure that the student is identified and introduced to available services quickly and efficiently, the Center has developed an organizational model which consists of four major units: Admissions, Student Support Services, Specialized Programs, and Human Resources.

ADMISSIONS UNIT

The Admissions Unit is responsible for coordinating recruitment and orientation and assists in identifying students. Referrals are made to other units of the Center as needs indicate.

Recruitment and orientation activities include presenting Center programs and services to agencies, organizations and professional groups, processing inquiries from individuals and groups, and maintaining a comprehensive, current list of interested agencies and groups in order to insure that agency clients are properly integrated into an appropriate program.

In order to justify and offer referrals to each student and to help him develop an individualized career plan, the Admissions Unit gathers information on each student regarding the functional effects of their disability, vocational strengths and weaknesses, educational histories, and specific goals. To assist students who cannot communicate clear vocational goals, the Center added the Vocational Assessment Office to its service delivery model. This office administers interest, aptitude, achievement, and personality tests which guide students in career exploration and self-assessment. Work samples, which stimulate activities in the working world, are also used.

This model of intake has been designed to be flexible in its delivery. The services can be offered either within the City Colleges of Chicago or at various sites within the community.

Currently, the Center is conducting these services within 25 Chicago public high schools for 350 graduating seniors who hope to effect a smooth transition between secondary and postsecondary educational institutions. The Department of Children and Family Services and the Unified Delinquencies Intervention Services have contracted with the Center to provide similar activities for individuals who are 17-21 years of age, wards of the state, or require special services.

Utilizing the outcomes of this process, individuals identify the type of program they desire and are referred to the Student Support Services Unit or the Specialized Programs Unit. Students may also be referred to appropriate support or training agencies in the community.

STUDENT SUPPORT SERVICES UNIT

Students with special needs who are interested in regular academic/vocational credit programs are referred by the Admissions Unit to the Student Support Services unit. This unit has an office at each of the nine City Colleges of Chicago and each is staffed by a professional Special Needs Advisor who serves students on a daily basis. Special Needs Advisors are able to assess the needs of students related to daily student life. A campus location also affords Advisors the opportunity to establish referral networks within the individual college offices and with campus personnel.

Beyond the referral services of the Admissions Unit, the Student Support Services Unit coordinates direct services to disabled students. It hires support personnel such as readers, note-takers, interpreters, transcribers, and personal care assistants. It ensures that tape recorders, magnification devices, and other adaptive equipment are available. Workshops and individual instruction sessions in educational survival skills, time management, study skills, and exam strategies are offered to disabled students. Referrals for these services and suggestions for additional workshops come from both college and community sources. Student Support Services personnel also provide campus faculty, staff, and administrators with disability-related training and consultation for adaptation of curriculum materials for special needs students. Follow-up guarantees that services (activities) are adequate and appropriate to individual students.

SPECIALIZED PROGRAMS UNIT

In response to an expression of interest from the individuals and the community, the Center created the Specialized Programs Unit to provide non-credit instruction for special

needs populations unable to take part in or uninterested in academic credit at the City Colleges of Chicago. The specialized programs offered are the Vocational Training Programs, Educational Programs for Developmentally Disabled Adults, Adult Continuing Education for Professionals, and Programs for the Hearing Impaired.

The Vocational Training Program provides hands on vocational training for developmentally disabled adults. Training programs are available at different locations throughout Chicago: maintenance, laundry, and food services at the University of Illinois Chicago Circle campus; hotel services at the Hyatt Regency Hotel; and hospital services at the University of Illinois Medical Center Hospital. Training Specialists and Job Coaches at each location coordinate support services, oversee the training program, work with students, and consult with other employees and supervisors to explain the needs of the trainees. A referral network that includes the Center, the Colleges, the community, and Vocational Training Program personnel helps to direct potential students to the program. Job searching skills and time and money management are taught in prevocational skills classes. Job Placement Specialists help students who are ready for employment to find jobs. Program personnel provide follow-up to insure a smooth transition into the work place.

Educational Programs for Developmentally Disabled Adults provide educational opportunities to developmentally disabled adults through classroom programs. The Educational Programs Unit offers services through the Learning for Life Skills Programs and Literacy Classes. These classes are integrated into the College System whenever possible.

The *Learning for Life Skills Program* offers classes at six campuses through the Adult Continuing Education Department. While classes are in session, each site is supervised by an Educational Specialist who assesses student needs, refers students to resource materials, and monitors resource use. Non-credit classes are offered in areas of functional academics, pre-vocational skills, independent living, and enrichment. A low student-teacher ratio is maintained. Classes are also offered at approximately ten community sites in order to provide access to the services to those developmentally disabled adults who are unable to travel.

Specialized Literacy Classes focus on the development of basic reading and math skills. They are offered at four campuses and are co-sponsored by the Adult Continuing Education Department.

Adult Continuing Education for Professionals provides non-credit and college credit classes for professionals and paraprofessionals who work with developmentally disabled adults. Topics covered include parent advocacy, first aid, cardiopulmonary resuscitation training, and behavioral intervention techniques.

Programs for the Hearing Impaired offer self-contained classes in reading, language, math remediation, social skills, and prevocational skills through Adult Continuing Education. Program personnel deal with student assessment, referrals to resources, and follow-up activities. In-service sessions and workshops for professionals regarding the needs of hearing impaired individuals are also available. Sign language proficiency and development are offered to maintain standards among professional staff.

HUMAN RESOURCES UNIT

The Human Resources Unit is responsible for posting jobs, screening applicants, and referring qualified candidates to appropriate units of the Center for interviews. In addition, personnel provide training and staff development activities for hourly support personnel and professional staff.

To insure that the Center complies with current legislation, Human Resources Unit personnel research and produce policy statements reflective of guidelines and mandates. Necessary programmatic adaptation is recommended based upon this research.

CONCLUSION

Providing a wide range of services and programs to disabled students requires careful planning and implementation. As described in this report, the Center for Disabled Student Services has developed a flexible and comprehensive model for delivering services to students. By utilizing the organizational model, the Center encourages students to meet individual goals and

insures that the resources of the City Colleges of Chicago are accessible to disabled students.

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18 • Non-Traditional Career Approaches for Disabled Nonwhite Persons

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Abstract

The purpose of this paper is to explore specific strategies that facilitate successful career preparation for nonwhite disabled persons. Towards that end, it will address some non-traditional career approaches which can enhance the employability of these individuals.

THE NONWHITE DISABLED: WHO ARE THEY?

Before discussing specific strategies, it is important to identify the target population. The Bureau of the Census (1981) indicates that 22.6 million Americans are occupationally disabled. Of these, 4.2 million, or about one-sixth, are nonwhite. They are either black, Hispanic or Asian American in origin (Pape, Walker, Quinn, 1983).

Further, there have been significant changes in the demographic make-up of the American population in recent years. There has been an influx of refugees from Asia, Africa, and Central America. The new entrants generally settle in large urban areas and within communities similar to the parent countries. Language, social, and cultural differences make assimilation into American society difficult for them. However, many of these immigrants bring with them a host of problems, including medical, psychosocial, and educational limitations which make

their entry into the job market even more difficult. Hence, service delivery systems such as social and rehabilitation services, public schools, and training institutions need to accommodate the different forces of a society in transition.

THE ROLE OF WORK

The role and concept of work is also changing. With the unprecedented advancement of technology, the need for unskilled workers is diminishing. In the past, individuals with limited education and technical skills could find employment in service and labor intensive industries. Increasingly, jobs which require specific knowledge and skills, a higher level of education, and higher levels of abstracting/conceptual skills are replacing traditional employment opportunities for unskilled workers. Furthermore, discriminatory practices against nonwhite persons in the past kept them out of the mainstream of American life. The impact of these practices and technological advancements has been even more far-reaching for nonwhite *disabled* persons who are less educated and have limited marketable skills.

CHARACTERISTICS

Blacks and other minority disabled persons proportionately outnumber white disabled individuals by almost two to one. They are generally older and have less than a tenth grade education. They tend to be unemployed, have an income of less than $3,000 a year, and have a past employment history in service occupations (Bowe, 1983).

Research in the field indicates that there is a high causal relationship between disability and service occupations. These occupations are more physically demanding and pose greater health risks to the employee. Many of those injured on the job can be helped with medical intervention and job modifications. Unfortunately, many of those disabled by service-related injuries have limited education and skills for retraining. Thus, lack of timely appropriate medical intervention and persistent physical stress cause relatively minor and treatable injuries to become chronic and permanent disabilities (Bowe, 1983).

There is also a positive relationship between socio-economic status and health. Keserling (1965) points out that the proportion of those disabled or limited in their major activity by chronic ill health sharply rises as income falls.

RESEARCH—SOME RELATED FINDINGS

Tiffany, Cowan, Tiffany (1970) state that socially deprived individuals learn to live by reduced needs. The "rewards" of a better life are not meaningful to them. They cannot make the upward switch easily. The value system of the service provider and the individual conflict, and the client often discontinues services. A period for conflict resolution needs to be provided when planning rehabilitation.

In a model training program in southern Texas, handicapped secondary students were taught specific skills needed by employers in the community. Each student was paired with a prospective employer. They had the skills and liked their jobs and the employers with whom they were going to work. Outwardly, the employer and employee were carefully matched. Yet, the students failed to report to work as expected. The trainers analyzed the situation and found that in families where the father did not work five days a week, the son did not report to work. This required that surrogate role models for students be developed. During the training and career planning period, teachers who reported to work everyday were role models for appropriate behavior. This shows that cultural values and expectations need to be considered at every stage of planning for the nonwhite disabled persons.

Another variable of extreme importance for ensuring success in planning is communication. Pouissant (1969) discusses the need for effective communication with "the poor." He stated that "most middle class folks do not respect the poor and consider them inferior beings." He continues: "It is felt that anyone who works hard can succeed and those who are poor are 'failures'." Since a significant proportion of the nonwhite disabled are poor, professionals who work with them need to communicate a *genuine interest, commitment* and *understanding.* Kent (1980) writes about her teaching experiences in rural Mexico and states that the disabled from different cultures have different needs. Yet, "beneath the discourage-

ment, beyond the cultural differences, the need for acceptance, independence, and self-respect is universal."

There is considerable ambivalence on the part of professionals with regard to working with disabled nonwhite persons. Ayers (1970) notes that negative counselor trainee attitudes affect building rapport with the minority disabled. Kolk (1977) reported that counselor trainees working with black clients reported greater psychological stress than while working with whites with intellectual and physical disabilities. Buchanan (1973) reported that rehabilitation counselors had more negative perceptions and attitudes towards poor black families than towards poor white families. Riggs (1979) states that counselor trainees were more uncomfortable working with disadvantaged blacks than with whites during their training.

Thus, conflicting value systems, poor communication, negative perceptions and attitudes about minorities in general and the disabled in particular, set the stage for failure. Issues relating to developing appropriate career options need to be addressed within the context of the cultural norms and values of those being served.

In view of the above, discussion of career strategies will be built around four subtopics: (1) the person, (2) disability, (3) asssessment, and (4) employment. This is a systematic approach that needs to be used within the framework of the disabled person's cultural and value systems. Specific examples will be provided in the course of the discussion of these subtopics and general strategies will be outlined at the end of the paper.

(1) The nonwhite disabled person's
   (a) Group affiliation (ethnicity)
   (b) Family/group's definition of disability
   (c) Cultural perception of disability
   (d) Individual/family/group participation in planning intervention
   (e) Record of utilization of available resources, etc.
   (f) Level of initiative and risk-taking behavior
   (g) Economic level

The Awareness Papers of the White House Conference on Handicapped Individuals (1977) state that man is the product of socialization and enculturation. Implicit in this statement is an understanding that there are significant differences in the manner in which cultures define problems, devise intervention strategies, and utilize available services. Hence, the person needs to be viewed within the context of personal, family, and community values as well as the functional assets and limitations imposed by his disability (Pape et al., 1983). For example, Asian Americans perceive disability as a curse for sins of the individual or his ancestors. Within this framework, the government is not obligated to provide services. Consequently, persons from this community do not readily seek services and are generally mistrustful of public service delivery systems (Chan, 1976).

Therefore, the background information regarding the disabled person, in terms of the above subclassifications, becomes extremely valuable. The strategies to be employed depend upon "where the person comes from" and "where he wants to go." Disabled nonwhite persons who have never attempted to access services will need to start at a different level than those who have been in a public service delivery system. For example, a handicapped adolescent who has been in special education classes all his life will need specific career exploration and direction. On the other hand, a middle-aged nonwhite person who suffered injury on a construction job will need strategies that will identify his potential for training in another area. The same type of analysis will need to be applied for other aspects of the person's background.

2. Disability
   (a) Disability (specific)
   (b) Onset and specific limitations
   (c) Intellectual/educational/vocational history
   (d) Training past and present
   (e) Family/religious/cultural affiliations
   (f) Specific needs for management of disability

In general, acute traumas suffered during post-school years by persons already in the work force have the best prognosis for rehabilitation and adjustment. Chronic illnesses, whether they are physical or emotional, and prolonged periods of intervention, or the lack of it, are the most difficult and require long range planning: hence, the need for the above-mentioned subclassifications under "disability" in developing appropriate career strategies. As far as possible, the person's

immediate support systems (e.g. family, religious affiliations, and community resources) will ensure smoother transition into training and the world of work.

For example, a 30 year-old black male with a high school education and trained as a cable installer in a telephone company injures himself in an automobile accident. The accident leaves him extremely limited physically and incapable of returning to his previous employment. He does have good academic skills and high potential for retraining in a less physically demanding occupation which can be used to his advantage. On the other hand, a 25 year-old black woman with a history of mental illness and frequent hospitalizations poses a greater challenge for rehabilitation practitioners. Besides requiring long-range planning with multiple short-term goals and objectives, the prognosis for her being successfully rehabilitated is guarded: hence, the importance of information regarding disability, its onset, and limitations.

3. Assessment
   (a) Current psychological and educational functioning language proficiency—post-disability onset
   (b) Vocational assets and limitations, potential for retraining; if so, specific areas
   (c) Environmental modifications—home, job site, psycho-social adjustment needs, etc.

The assessment procedures are generally structured and utilize stardardized instruments of objectivity. However, there are built-in biases which negatively affect the less educated nonwhite disabled population. Ideally, data analyses should include specific ramifications of the disabling condition along with the person's background, exposure, experience and culture.

For example, a 25 year-old disabled black male with a tenth-grade education, a history of academic failure, and a sporadic employment record, tests in the average range of intelligence, but is functionally illiterate. His disability—a leg injury—poses considerable physical limitations on his career potential. A systematic assessment of his specific assets and limitations will be needed to identify clusters of skills he might possess. The career planning process will need to include his past record of employment, the necessary components of behavior which need to be changed and which will ensure successful participation in the program, and specific areas for remediation geared towards specific vocational objectives. Thus, the dimension of assessment becomes very valuable for planning and developing career options of a disabled person.

In order for this type of assessment to be meaningful, Organist (1983) recommends five steps for practitioners. The first is that the evaluator is provided with the complete referral information about the disabled person. The greater the knowledge and understanding of the person's background, the more clear and discreet will be the results of the evaluation. The second point pertains to evaluator training. Individuals involved in assessment of disabled nonwhite persons *must* be appropriately trained to be effective. The third issue is evaluator competency. There should be periodic reviews of the evaluator's level of knowledge and skills and appropriate training should be provided when necessary. The fourth point pertains to the client's or disabled persons's preparation and readiness to participate in evaluation. No matter how skilled the evaluator is, if the client is not motivated, the assessment program will be meaningless. Lastly, a great degree of caution must be exercised in data interpretation. Overemphasis on standardized test data can lead to erroneous conclusions and faulty vocational planning.

4. Employment
   (a) Marketing trends in employment—availability of specific jobs
   (b) Employer characteristics—personality, awareness needs of disabled nonwhite workers
   (c) Specific strategies for identifying employment opportunities and modifications
   (d) Matching specific employees with available jobs
   (e) Follow-up services by the placement person/counselor/social worker—support for employer and employee

Professionals need to keep abreast of the employment trends in specific areas and regions and the type of skills which are in demand at any given time. For instance, in the Washington, D.C. metropolitan area, federal, state and local governments are chief employers. Openings occurring most frequently require specific skills and training;

often college level education. Other industries are building maintenance, hotel and restaurant management, and trade associations. Since disabled individuals present different levels of abilities, job development should be focused on all levels of position openings. Many disabled persons can enter the mainstream of employment with minimum modifications. Some may have disabilities which require no adjustments or modifications. For example, a ramp for a mobility-impaired person can ensure accessibility and may be the only modification he needs. Job modifications involve anything from technical aids to job-sharing.

This brings us to the next issue—employer characteristics, which facilitate employment opportunities for minorities. Regardless of ethnicity, some people do not want disabled persons around them and will not hire them. Others accept the challenge and others need to "see" for themselves how hiring a disabled person will benefit them.

One important point to remember about identifying employment opportunities in the private sector is that industry is in the "business of making money." When identifying employment opportunities in this sector of the economy, it is necessary to employ strategies which enhance the productivity and the profit margin of the employer. Qualified, hard-working disabled persons can be easily "marketed." The employer tax credit for employing a disabled person is just one incentive.

It is suggested that small neighborhood businesses be tapped for employment opportunities, including volunteer and part-time work. This type of placement provides opportunities for skill building training which the handicapped persons may not get otherwise. Counselors with good interpersonal skills and a carefully planned public relations strategy can facilitate this activity. However, developing a "willingness" in the employer to participate requires more than one strategy, visit, or contact. The placement officer becomes the catalyst and a support system between the employer and employee when he develops partnerships and ongoing relationships with the business community.

Strategies for job development are many and varied. A practitioner can start with getting to know the neighborhood from which he gets the most cases. Small local businesses, area churches, civic associations, and public schools are potential employers and offer possibilities for creative job development. One possible strategy would be to recognize a successful disabled person in the community by publicizing his achievement. An individual or a group who made the most contribution in that effort can be rewarded. Many disabled persons do well when they start building skills in their own neighborhoods. Familiarity with their surroundings at the initial stages of rehabilitation dispels the conflict they experience from the expectations of family and friends and the values of the professionals—counselors and other employees—working with them.

Follow-up services by the counselor and placement specialist are an integral part of the process of job development. Many disabled employees have severe limitations in performing simple activities of daily living. They need built-in systems at the place of employment. For example, a quadraplegic may need to get out of his wheelchair for part of the day. Initial job modification ensures that this is built into the daily routine. However, the employer should know that there is a support system available should there be breakdowns in the established system. This linkage ensures smoother transition for the disabled person and the employer.

INNOVATIVE APPROACHES TO CAREER PREPARATION

In the past, educators focused mainly on areas of study leading to degrees and diplomas in higher education. Those who could not meet the standards generally dropped out and found employment in farming or other labor-intensive industries. Increasingly, there is a demand for education and training in areas which offer the most opportunities. One just needs to review the enrollment trends or become acquainted with labor projections to realize this.

If nondisabled students are planning their future careers at a much younger age to keep abreast of employment trends, then disabled students need to start even earlier. This is particularly necessary for disabled nonwhite students who have to battle considerable cultural, social, and family prejudices about their disabilities to become independent and achieve their full potential. Environmental modifications and accom-

modations need to begin early in the life of a disabled youngster. It is felt that the more disabled the person is, the earlier he needs to start planning for his career.

The national initiative emanating from the U.S. Office of Special Education and Rehabilitative Services, U.S. Department of Education, "Transition from School to Work," spells out the planning process quite vividly. It is designed to bridge the learning gap between school and the workplace. There are many research and demonstration projects in progress in many states. However, the processes and procedures outlined in the initiative need to become part and parcel of the national education policy.

This concept has been fully developed at the national level in certain countries such as Australia. A brief summary of innovative placements of special education students is presented.

1. (a) The first strategy is embodied in what is called work therapy or on-the-job training. This has proven to be an excellent way to prepare handicapped students for the world of work. Closer to home, this strategy can be extremely valuable for disabled minority students who do not get opportunities to develop appropriate job-related skills and behaviors or lack strong role models in the home. This type of exposure needs to start early and can be either voluntary or paid experience, depending upon the circumstances and needs of the person.

   (b) Another approach is developing a series of job opportunities which pay remuneration at graduated levels as the student masters the tasks. The starting salary is generally a percentage of the adult full-time wage. As the person moves up from simple and routine activities to tasks requiring greater independence and higher skill levels, he qualifies for the full adult wage. These jobs do not have to be competitive, which might conflict with unionized positions, but should be strictly earmarked for training purposes. Supervision and skill-building should be the responsibilities of the special education teachers. This type of placement serves a two-fold purpose. Firstly, from the employer's standpoint, it offers an opportunity to observe how a prospective disabled employee (whom he is not required to hire at the end of the program) functions in a learning and employment situation. Secondly, from the student's perspective, it provides meaningful learning and skills which are more easily transferable than if they were taught in a classroom. In addition, it identifies those students who function independently and can be earmarked for appropriate independent living arrangements in the community.

   (c) Some students, even with early planning and training, will not be quite ready for employment at the time they leave school. They will need other services and more sheltered placement upon completion of their school tenure. For them, a "School Leavers Program," as it is called in Australia, may be very helpful. In this program, a diagnostic team—consisting of a medical consultant, a psychologist, a special education teacher, a placement specialist, and an appropriate therapist—meets with the student and his parents or guardian to discuss future needs. Other government or educational services are identified and linkages are established long before the student actually leaves school (Desmond, 1983).

2. Job development efforts need to be directed towards the minority communities which can increase opportunities for disabled youth. Light (1980) demonstrated that minorities have done well in small enterprises within their own communities i.e., Cubans in Miami. Gradual step-by-step progress towards adaptation to different values is facilitated when disabled persons stay within their own communities during the initial stages. Such "learned" behavior can be transferred to other settings later on.

3. The importance of role models cannot be overemphasized. Kent (1980) states "... many disabled Americans from

minority groups have never met another handicapped person living a full productive life, especially not a black or Hispanic or Asian." The blind lawyers, the deaf teachers, the executives in wheelchairs are all white and from higher income brackets. They speak for the disabled and address the issues for all handicapped persons. Professionals working with minorities need to understand that the usual rehabilitation programs are not necessarily the best for everyone. The success of the individuals makes the program successful and not vice versa.

4. Counselors and others involved in "direct services" to the minority disabled need to become activists and community advocates since community attitudes impact negatively on the placement of handicapped persons. In order to be successful, it is necessary for this activity to be targeted at the grassroots level. This is different from memberships on task forces and other agency representation activities. The latter are also needed to effect change and provide input for legislative action to ensure budgetary allotments and the like for programs in the area.
5. Counselors, school teachers, guidance counselors, and parents of disabled children need to take an active role soon after a child's disability is recognized. Rehabilitation counselors can provide valuable technical support at Individual Educational Plan meetings and develop on-going communication with all parties. They can speak at PTA meetings and in-service teacher training programs. In all, these linkages can be helpful in providing a continuity of services and save valuable time later on. Appropriate social and independent living skills can be built into educational programs.
6. Community resources can be utilized to provide appropriate experiences to the handicapped adolescents. Neighborhood leadership, retired citizens, and church members can be tapped for support as role models or as "big brothers" or "big sisters." Again, local involvement ensures systematic adaptation of behaviors and adjustment of the disabled nonwhite individual.

In summary, career exploration and preparation for disabled nonwhite persons involve in-depth understanding of the individual person within the context of his family and friends, community, and culture. The same type of analytical thinking must be employed with reference to his disability, assets and limitations, and employment needs. Specific strategies will depend upon the assets of the person and how they can be utilized in the market place.

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19 • Work Experience Program for Disabled Students in the CUNY System: Implications for the Nonwhite Disabled

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Abstract

The purpose of this work experience program was to develop and implement a model program that would allow disabled college students in the CUNY system to experience short-term unsubsidized employment in the private sector. Students would also be trained in the skills such as personal budgeting, banking, and developing self-support plans needed for them to cope with real life. Of the 25 students participating, 65% (16 students) were Black, Hispanic, or Oriental. Six students were placed in full-time unsubsidized summer employment in various business firms. The remaining students received work orientation, personal management, and other job-related training which readied them for employment in subsequent phases of the program. Not only has this program brought disabled college students and the marketplace closer, but it has provided disabled students with a newfound confidence in themselves. Disabled college students earn and manage an income. Implications of the results and guidelines for future program developments are discussed.

Recently, a deaf student participating in our program plaintively posed the question, "Why is it that no one seems to think disabled students need to be prepared for the world? It's easier," she said "for people to pity us than give us the tools to get ready for the world."

Her summary underscores the evidence that this population requires a comprehensive vocational preparatory program. Indeed, the traditional readiness model needs the co-existence of a support model. This is even more true for members of minority and dis-

advantaged groups who are disabled. Evidence points to these populations as being "extremely high risk" in terms of vocational/career development.

The relevance of a school-to-work transition program for disabled students is clear. They do not enjoy the same opportunities for casual, part-time temporary or summer work experiences that are available to their able-bodied counterparts. Studies reveal that disabled youth lack understanding of their capacity and have a record of inappropriate job choices as compared with non-disabled youths in the same age group. This is compounded by lack of expectations from the family, teachers, and other professionals vis-a-vis these students who consequently display a high degree of dependency and lack a sense of responsibility.

Each year, approximately 20,000 to 30,000 severely disabled students leave public special education programs. Many face bleak employment futures although an increasing number are now entering college. However, even with more advanced education, the jobless rate of disabled people remains between 50% and 70%. There is a need for a blend of support work strategies that will enable the members of this population to make a successful transition from school to work so that they can develop a strong foothold in the primary labor market in order to move from a receiver role to one of decision making and to social and economic independence.

With this in mind, a program was designed to provide a multi-faceted school-to-work transition program for disabled students in the City University of New York. The program, funded by New York State Department of Education, is to provide disabled students with short-term unsubsidized employment in the business sector along with comprehensive training in the skills needed to cope with real life.

In the 1980s, we are experiencing major shifts in social service concepts. Current trends favor more use of the profit-making sector and more relevant preparation of students for work. These trends are particularly appropriate when disadvantaged people need to be brought as quickly as possible to the stage where they no longer depend on sorely strained social services and where they are capable of further development growth.

OBJECTIVES

The program's present objectives are:

a) Mainstream 25 physically, visually, or hearing impaired college students into short-term unsubsidized employment in the private sector, i.e. the employer pays the salary.
b) Enable students to acquire and increase their knowledge of the world of work and careers in order for them to make career decisions based on first hand experience.
c) Provide comprehensive and coordinated services which include teaching real-life skills such as personal budgeting, banking, and developing self-support plans.
d) Familiarize private industry with qualified disabled students as a viable manpower source.
e) Increase the expectations of family/college faculty/personnel concerning this target population.
f) Provide programmatic flexibility.

PROGRAM DESIGN

Recruitment of students is carried out (1) through contact with the coordinators of disabled students on the individual campuses and (2) through self referral. Attention is paid to a student's medical status to determine work tolerance and counter-indications and to a student's academic record to ensure that participation in the program will not affect school work.

One of the important characteristics of the program design is flexibility. Rather than create a structure wherein students proceed through program components in a specified order, they have the opportunity to explore the program vis-a-vis their own needs. This approach affords students a choice. They select aspects of the program most relevant to them. It also provides them with a more meaningful experience and encourages decision-making and responsibility. For example, a student may elect to investigate work disincentive solutions prior to initiating interview preparation, while another student may choose to spend more time on skills and functional assessment. Some students need to address special issues first such as planning for personal care while at work, or negotiating transportation options.

Others request information and counseling on types of jobs and career paths available in their chosen major.

SEMINARS

A number of students begin to participate in the program by attending the program's seminar series. So far, the subjects addressed in this series include personal budgeting and banking, computers and adaptations, and disincentive solutions. Next month the seminar topics will include "Sports and Physical Fitness For The Disabled," "How to Research a Career," and "Purchasing a Car and Insurance For It." Faculty for these seminars are drawn from the business sector, independent living centers, and other community resources.

Students receive asssessment of functional capability and work skills as well as preparation for interviews and relevant counseling. Preparation for job interviews brings into play a number of facets of the program. Detailed job descriptions are utilized by students to relate their capabilities to the requirements demanded by the job. For example, a bank was administering the finances of a concert tour. The job required fast and accurate scanning of recorded ticket sales. A work sample was developed and the student candidate was able to assess herself immediately and meaningfully.

Students are assisted in developing a level of job preparedness acceptable to the job marketplace and in presenting themselves effectively in interviews. Follow-up interviews with students and interviewers provide valuable feedback. Subsequent job preparation sessions utilize the experience gained to improve the students' presentations.

A strong link has been forged with the business community by the staff as well as the business representatives on the program's Advisory Board. Companies are informed about the program by phone and personal visit. Jobs relevant to students' career objectives are identified and analyzed and worksites are evaluated for access.

After placement, follow-up is carried out on a regular basis both with students and supervisors. Progress reports are shared with each student and with their individual advisor/counselor on campus.

Of the 25 students enrolled, 65% or 16 are black, Hispanic, or Oriental. Of the six* students ready for employment, all were placed this summer in full-time unsubsidized employment lasting 8 to 12 weeks as follows:

Disability	Wheelchair/ Ambulatory	Academic Year	Job Title	Salary (weekly)
Bilateral Leg Amputee	Wheelchair	Graduate	P/T Admin. Asst.	$7.00/hr
Cerebral Palsy	Motorized Wheelchair	Junior	Management Intern	$230
Cerebral Palsy	Ambulatory	Junior	General Clerical	$210
Hearing Impaired	Ambulatory	Junior	Jr. Engineering Technician	$170
Multiple Sclerosis	Ambulatory	Sophomore	Clerk/Typist	$200
Traumatic Leg Injury	Crutches Ambulatory	Freshman	Unit Assistant	$150

*Four are minority students.

The positive impact of these placements on the students has been startling. On entering the program, one student—severely disabled due to cerebral palsy—expressed surprise that people with the severity of disability similar to or greater than his own, were actually working. He had always believed that he would have to be homebound even though he is a talented computer programming student. We placed him with a large firm as a "Management Intern" in the computer department. His abilities were quickly recognized, he related easily to colleagues and supervisors, and rapidly became an integral member of the staff. He was eager to meet deadlines and happy to take on challenges. His supervisor wrote the following comments on his performance rating: "M's overall performance was excellent. He displayed an enthusiastic attitude towards his assignments while demonstrating his ability to learn quickly. In addition, many of his ideas were utilized in developing the system." The student's own comment is telling: "I have learned that I can be on my own." He has been invited back next summer by the company.

A minority student with cerebral palsy who had never worked before was placed as a library research assistant in a large bank. She also performed exceptionally well and developed a strong sense of self. She displayed a newfound confidence because she discovered that she could function well in an unfamiliar environment.

All of the students who were placed realized that they indeed have the ability to work, to earn and manage an income, to interact well with people, and to be less fearful of unfamiliar surroundings.

These students who are "graduates" of the program's first cycle are now becoming members of the program's "faculty." Their advice and counsel will be of inestimable value to enrollees.

FACULTY SEMINAR

Recently, a special seminar was held to help faculty develop their awareness of the vocational potential of these students. The panel included a corporate recruitment officer, a corporate employment manager, a corporate staff manager responsible for seeking job accommodation solutions, and three disabled people in different professions—medicine, law, and accounting. The moderator, totally blind, holds a doctorate and is director of a special computer project within the CUNY system.

The panelists shared experiences and advice with the faculty and time was available for questions. The topics addressed were: "Bridging the Academic and Work Worlds," "College Recruitment—The Roles of the College and the Corporation," and "Corporate Responsiveness."

ADVISORY BOARD

Two additional aspects of the program must be noted. Firstly, the program has an active Advisory Board which reflects the partnership of business, academics, and community. They participate as employers, seminar faculty, evaluators, interviewers, advisors, and resource personnel. Meetings are held every couple of months, but members are contacted regularly for advice and guidance concerning individual students.

REDUCING "RED TAPE"

Secondly, bureaucracy can be a stumbling block for populations such as ours. It is not unusual for people to encounter a maze once they tap a system. Too often, people who would benefit from particular programs are discouraged from applying because "conditions for eligibility" are burdensome, confusing, or negatively affect benefits received. In the course of planning this program, we decided to eliminate bureaucracy as much as possible. We believed that this would not only be a welcome change but, more importantly, would allow students direct access to the program. For example, eligibility criteria are minimal—at least 16 years of age; presently enrolled in the CUNY system; have a physical, visual or hearing impairment; independent during a work day; and have had some exposure to work (summer or volunteer). Filling out forms is kept to a minimum. In fact, the students' certification process required by the Department of Employment has been curtailed. There is no formal intake procedure and the only documentation required of the students is that of income and disability status. There are no long delays in enrolling in the program. In sum, the

absence of bureacracy enables the program to be responsive.

Of course, problems arise in every program. Transportation is the most common problem and the biggest problem in any program for the disabled. Budget constraints in the grants' guidelines precluded transportation as an expense although in the next cycle of the program, transportation is an item under consideration for inclusion.

It is evident from a number of programs that about 50% of the participants require transportation. This has proven to be so with our present enrollees. In order to facilitate travel for these students to the various components of the program (e.g. interviews, seminars, daily commuting), we have relied on generous cooperation from independent living centers that have accessible vans. We have also received a handsome donation from a group of executive women who became interested in our program and the students have paid for their own transportation out of their paychecks.

Programs such as the one described bring disabled students and the marketplace closer. There is a clearer understanding of a potential labor source and the demands of the primary labor market. Business and industry can advise and guide the potential employee towards better preparation for the work world, community resources can provide support, and the disabled students can illustrate their abilities and gain more widespread acceptance for the disabled in the business world. The results present a brighter economic picture for the future from all aspects.

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20 • The Role of the Black Church in Advocating for the Disabled Community

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Abstract

This article examines the role of the black church in advocating for appropriate rehabilitation services for minority disabled individuals. Depending upon the insight, commitment, and creativity of the core group members and the congregation, the church can provide a client support program which would facilitate on-going emotional and social needs in addition to ensuring a smooth transition and success in the mainstream of society. Described is a client support model, Project Helping Hands, fashioned after the Howard University Rehabilitation Model. The reader will acquire a sense of what the black church can do by collaborating its efforts with various agencies and community resources.

In January 1984, the Howard University Model to Improve Rehabilitation Services to Minority Populations with Handicapping Conditions, funded by the National Institute of Handicapped Research, in collaboration with the United Methodist Churches of Rome and Cedartown, Georgia, conducted a Resource Exchange Conference titled "Meeting the Rehabilitation/Social Service Challenge." The conference focused on state-of-the-art issues of ethnicity/disability and how these statuses affect the minority disabled in accessing the rehabilitation system.

Pape (1983) confirms that ethnicity/disability compound the rehabilitation process for minority persons. The goal of the Resource Exchange Conference was to explore effective modalities and initiate a plan of action to address the barriers which inhibit and impede the rehabilitation process of minorities in the southern Georgia area. This is the etiology on the development of the client support model, Project Helping Hands, a replication of the Howard University Rehabilitation Model. The church has long been recognized as a major therapeutic and survival force in the black community (Ambrose, 1977). Project Helping Hands, a volunteer client support model, was intended to demonstrate the potential impact of the black church upon the service delivery pro-

cess by facilitating complex service needs of minorities with disabilities.

CLIENT SUPPORT DEFINED

The concept of client support as described in this article should not be confused with the Client Assistance Program (CAP), whose mission is to improve the delivery of vocational services by resolving differences between vocational rehabilitation clients and the agency (Division of Vocational Rehabilitation, Charleston, West Virginia, 1981).

The overall structure of a client support program as instituted by the Metropolitan United Methodist Church is one of outreach. It provides and maintains emotional support, social interaction, and an atmosphere of family unity and involvement in the mainstream of community activities for the disabled who have not accessed the rehabilitation system. The program also serves clients who may not be knowledgeable about rehabilitation procedures and its transitional stages.

The structure of a client support system is viewed as critical if it is to help disabled individuals cope with their feelings of suspicion, uncertainty, and stress. These justifiable feelings are often due to the many transitional stages involved in the delivery of services in vocational rehabilitation or other social service programs.

Insufficient attention has been paid to the networking capabilities of the black church. This viable institution has a track record of success in developing, coordinating, and communicating with community, governmental, and private agencies. By virtue of the diverse skills and expertise among its members, the black church has always been actively involved with the problems of the inner city community (Delivery of Rehabilitation Services to Inner City Nonwhites, 1981). Thus, the black church can become a political force to be reckoned with as it advocates on behalf of the minority disabled community.

Disabled individuals of a minority group are a silent majority in social service and vocational rehabilitation programs. While disability is more prevalent among blacks (14%), than it is within the general population (8.4%) (Bowe, 1980), the number of blacks successfully rehabilitated for independent living or vocational rehabilitation is disproportionately smaller than their white counterparts (Atkins & Wright, 1980). While various factors influence the outcome of rehabilitation services (Humphreys & Provitt, 1980), the need for and availability of support systems are seen as critical.

Metropolitan United Methodist Church took on this support role by marshalling church and community resources to implement a client support program, Project Helping Hands. The goal of the project was to provide ongoing support and advocacy for disabled persons and their families in accessing the rehabilitation system and social service programs. By organizing its resources, Metropolitan responded to some of the indifferences and inadequacies of the rehabilitation system and other service delivery systems. It helped minorities with disabilities to become potential competitive employees in the job market.

ORGANIZATION OF METROPOLITAN'S CLIENT SUPPORT SYSTEM

Identification of the Core Group

Through surveying its membership, Metropolitan identified that a significant percentage of its congregation work in, or are retired from various professional, blue collar, or semi-skilled occupations. This core group shared their talents, expertise, time, and capabilities to design a plan of action for assessing and addressing the needs of the disabled community.

Outreach Efforts

One of the barriers that impedes the accessibility of services is the lack of knowledge and information about available services or resources. Core group members utilize outreach and public relations strategies—scanning the community, talking with neighborhood residents and agency personnel, making home visits, visiting hospitals and institutions. These outreach efforts facilitated the building of relationships based upon respect and empathy and not only enabled the identification of disabled individuals, but also acquainted the disabled and their family members with the existence of services and resources.

Resource Exchange and Untapped Resources

Conducting a resource exchange conference at the church facility serves to intensify

outreach efforts. This strategy afforded disabled individuals and service providers from a variety of settings (e.g. agencies, businesses, and institutions) an opportunity to assemble to discuss problems and concerns of the disabled community. Those organizations which provided services to or have interest in the disabled offered alternative strategies and solutions to some of the complex issues. On-going training efforts, workshops, and action groups, funding sources, and a networking system resulted from these efforts.

Peer Support

By linking the disabled with a core group member, the member utilized his/her talents and skills in addressing particular needs such as remediation. This avenue of pursuit offered social interaction and the establishment of a reciprocal relationship between the disabled and non-disabled. It also opens the doors for other non-disabled persons to become acquainted with the disabled and the opportunity to offer services.

Hands-On Experiences

Training centers developed or expanded from existing activities of church organizations (e.g. working in the food pantry, publishing monthly newsletters, organizing social functions, working with church budget). These activities allow exploration of vocational interest. It is postulated that positive experiences of this nature could change suspicion, apathy, and stress to motivation, self-esteem, and independence.

Through the initiation of any of the services aforementioned, a host of additional service provisions emerged. For as many audiences and individuals interacted upon, new resources were tapped. For every action positively and effectively executed, the need for a continued focus on community commitment was realized.

Skills and Action of the Core Group

- Exercising a spirit of willingness to give, share, train, and serve without need for tangible reward or credit for deeds. (Unconditional giving of oneself to help others.)
- Risk taking for the sake/good of others.
- Creative exploration in pursuit of avenues of opportunity for the service of others.
- Interacting for the purpose of providing emotional support and promoting strategies for endurance in trying times for others.
- Creating and taking advantage of opportunities to promote and provide for progressive/positive change for the good of others.
- Promoting simple, practical, innovative, and creative approaches to providing for the needs of others.
- Caring evidenced through sacrifice—time, talent, substance, interest.
- Dissemination/sharing information conducive to inspiring the replication of the model and evoking positive action.
- Serving with enthusiasm and joy.

It is evident from the issues highlighted in this article that a church-oriented client support system is an effective method to assist the minority disabled community in accessing the services within the system. Metropolitan United Methodist Church executed components of the SPEED Model to Access, an action oriented plan developed by the Howard University Rehabilitation Project, to facilitate the access process and to serve as a catalyst for meaningful participation of individuals. (The SPEED Model is outlined on next page).

The wheel of the SPEED model will roll either forward or backward. However, because access is the goal, the intent is to move forward. With the forward movement of the access wheel, communication and collaboration are facilitated and partnerships are established.

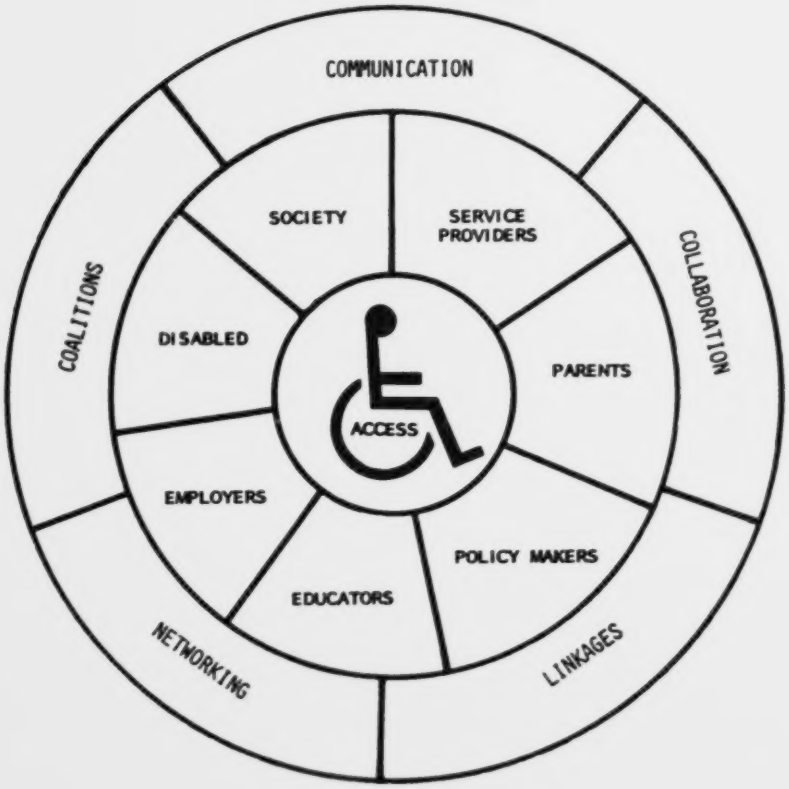
Partnership can be viewed in two parts: 1) what is being offered and 2) what is being sought. This relationship process would thus facilitate the integration of services and resources to insure access.

SUMMARY AND CONCLUSION

The outreach and supportive role of the black church has evolved in response to pervading inequalities and discrimination.

The support and advocacy role for the church represents a challenge in assisting disabled persons to become a part of the mainstream of society. In order to effectively accomplish this goal, the black church must become involved and committed to enhanc-

SPEED MODEL TO ACCESS



S: *SOCIETY*

Must employ and practice the ABC's of psychosocial development.

Develop positive attitudes, display empathetic behaviors, and act as change agents to facilitate the mainstreaming process.

Must advocate for the rights of the disabled.

P: *PARENTS*

Must initiate and establish parent/professional partnerships. Must be assisted in clarifying their personal and family ideologies toward the disabled. Must identify, plan, and employ life strategies to accommodate the needs of the disabled.

POLICY MAKERS

Must initiate policies that facilitate the attainment of maximum potential for all disabled persons regardless of their socioeconomic status, geographic location, sex, race, or ethnic background. Must be abreast of current theory and knowledgeable of exemplary program strategies, research/demonstration projects as a preface for future deliberations concerning policy for the disabled. Must base program development decisions upon relevant research findings.

E: *EDUCATORS*

Must utilize existing research literature to develop special education and related curricula which contains sound implications for career and vocational education. Must recommend educational policies that create bridges between special education and rehabilitation.

E: *EMPLOYERS*

Must be encouraged to become involved in sensitivity and awareness sessions designed to inform employers of the employment potential of the disabled.

D: *DISABLED*

Must communicate and collaborate with able-bodied persons to organize support groups.

Must take an active role in the political and legal arena in advocating for the rights of the disabled.

ing the lives of the disabled. Through its networking efforts, the black church could enable all disabled persons—especially minorities—and service providers to become better equipped to protect, ensure, and advocate for the rights of the disabled.

One note of caution is that the black church must be regarded as complementary to social and vocational agencies whose primary business is vocational rehabilitation.

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21 • Rehabilitation Information: The Local Resource Puzzle

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The University of Maryland Libraries

Abstract

The 1981 Institute on Rehabilitation Issues focused on delivery of rehabilitation services to inner city nonwhites (King, 1981). One of the observations made about this population was that their survival was often based on their own efforts to solve problems by utilizing a community-based support system. These support systems can also be characterized as social networks consisting of people and established relationships directed toward group or individual problem solving. These networks can include voluntary organizations (e.g.

fraternal or social service groups) that provide services for handicapped individuals; churches; the family; community-based programs (e.g. day care centers, senior citizen clubs, community-based physicians, banks); political or opinion leaders in a neighborhood (e.g. shop owners). Some of the failure of a holistic approach to vocational rehabilitation with minority populations can be blamed on the tendency for the vocational rehabilitation agencies and these support systems to operate in isolation. In some instances, the vocational rehabilitation and related services are simply not known to these individuals and the support systems must attempt to provide the needed services. In order for any disabled individual to effectively utilize available resources, he or she must know that those related services and resources exist. This article identifies a number of those resources, how to locate them, and facilitation of a free flow of information by them.

Rehabilitating disabled individuals to their maximum level of independence finds significant realization through the independent living movement. The three major programs comprising this movement are:

Centers for Independent Living—whose purpose is to help disabled individuals live independently in the community with the kind of consumer involvement that gives these individuals some control over the decisions affecting their lives.
Centers for the Handicapped—facilities which help disabled individuals to function in the community by providing services and programs in such areas as recreation, education, health care, social development, independent living, and physical and vocational rehabilitation.
Independent Living Residential Centers—which directly provide housing, attendant care, and transportation rather than only referrals to these services.

In a survey of 11 California Independent Living Programs (ILP), Stoddard (1983) reported a wide range of services including peer counseling, advocacy, attendant referral, housing assistance, and other referrals. The efficient dispensing of these, or any related, services is based on having current data on the availability of resources and on having supportive materials to aid the clients in attaining their goals for independence. It is therefore incumbent upon the ILP to provide access to the type of information necessary to fulfill the service delivery needs of the center and the personal needs of the individual. One way of doing this is to establish an in-house resource center that contains this information.

The focus of this paper will be on how the ILP can be an effective resource for meeting the information needs of disabled individuals. Specifically, the paper will define and organize an information center for an ILP by tapping into local resources and developing new resources to enhance that information support system.

DEFINING THE CENTER

Defining the resource center requires answers to the following questions:

1. Who are the people you will be serving?
2. What are their information needs?
3. What level of service do you want to provide—national, regional, state, or local?
4. Will you include materials in foreign languages or special formats?
5. How much space and equipment/supplies are available?
6. How many people will be required to provide the level of service you choose?
7. How much money will be required to provide the level of service you choose?

The answers to most of these questions will be program specific. But David Smith and Helga Roth describe some of the kinds of information that disabled people, in general, would require:

1. Who are the handicapped individuals in a certain location?
2. What is the nature of certain handicapping conditions and their causes?
3. Where are treatment, prevention, or rehabilitation services and facilities located?
4. What is the availability of aids, equipment, prosthetic devices, assistance, and product listings?
5. What is the availability of special training or education?

6. What special help in dealing with activities of daily living is available?
7. Where are the funding sources for research, programs, or organizations?
8. What are the financial assistance resources?
9. Who are the professionals dealing with handicapped persons, what are their associations, and where is the research being done?
10. What is the pertinent legislation?
11. What are the civil rights of handicapped persons?
12. What are the self-help groups related to specific conditions or problems?

From the point of view of the ILP, it would be logical to suggest that in the beginning, the primary services group would be the disabled participants in the program and the service providers associated with that program. Having decided whom you will serve, the next step will be locating information resources that have the materials necessary to meet the needs of your service population.

COLLECTING THE INFORMATION

Information resources can be characterized as: 1) national, state, or local, 2) general information sources and sources focusing on the needs of the handicapped individual, and 3) resources focusing on particular diseases or handicapping conditions versus functional problems, e.g. architectural barriers or civil rights. Efforts to simultaneously employ all of these types of resources by an ILP to meet all the needs of its users can lead to unnecessary duplication of existing services, confusion, and possibly a great deal of expense.

There are many potential sources of appropriate materials on or related to disabling conditions. The range of costs of this material can run from free to quite expensive. With a focus on local resources, the search should begin with the telephone book, local government, and public and college libraries.

With the white pages of the telephone book you can begin by using known terms, such as "disability," "rehabilitation," "deaf," "blind," "paralysis." Terms such as these can lead you to local chapters of national organizations which may have free or inexpensive pamphlet material. You may also find service providers such as equipment suppliers, rental agencies, or professionals that you could include in a resource or referral file. The yellow pages can also be a storehouse of possible additions to this referral file. Headings that you may find there include "crutches," "handicapped assistance," "handicapped equipment," "handicapped transportation services," "rehabilitation services," "social service organizations," and "van conversions."

However, telephone books can also be a stumbling block because they are not consistent in the terms they use. Knowing what you want or are looking for is no guarantee that you will find it. The telephone company's indexing terms may not be related to the terms familiar to you.

These semantic inconsistencies can be compounded when you use the telephone book to track down local government agencies or local offices of federal agencies. Each municipality has the option of calling an agency what it wants to and they frequently do. The user can find some comfort in the occasional cross reference from that which he knows to the appropriate entry. For example, in order to find "vocational rehabilitation" in the 1984 District of Columbia Telephone Directory, you are referred from "vocational rehabilitation" or "Human Services, Department of—Vocational Rehabilitation Administration" to "Social Services, Commission of."

In most localities of any size there is some sort of Mayor's Committee on the Handicapped. This can be an excellent source of free materials and information on what organizations and services exist in your community.

You can also expect to find some form of information and referral (I/R) agency or program. In Washington, D.C., there are two broadbased programs I would bring to your attention. The one which locates services and organizations related to handicapping conditions is the Information Center for Handicapped Individuals. I found this by looking under "information" in the white pages. The second source is the Community Information Service of the Public Library System. This is a more general I/R service, but it does have information useful to the disabled individual. In other localities you should be able to locate similar services in

the telephone directory by searching "information," "community," "Easter Seals Society," or "United Way Fund" for information on local resources that already exist.

In addition to this I/R function, libraries can be used to locate published material worthy of purchase for a resource center. These libraries can also help you in borrowing material from other library systems for short term use and review through interlibrary loan. Making use of the services of the public library does not necessarily mean that you must go to the library. Most public library systems have established procedures for serving disabled patrons. These include libraries for the blind and physically handicapped, services to the homebound, bookmobiles, books by mail, and telephone reference services. No doubt in the future you will be able to stay at home, search the online catalog, and request that the item be mailed to you.

By simply "letting your fingers do the walking" through the telephone directories, a wide range of materials and data can be acquired for a resource center.

Before leaving local resources, let me add that in developing and tapping into these local resources, you must never forget to use other people. In many instances, the individual—the private citizen—can often be your best source of local information. A neighborhood appliance repairman may be quite capable of repairing a wheelchair motor. The hardware store owner may know of tradesmen who can build the ramps needed to improve accessibility to a building. Many churches have specific programs and services to assist the disabled members of their congregations and the community. While possibilities such as these exist, they are not necessarily the kind to be listed in a directory or similar type publication. The only way to access these services is to get out into the community, talk to the people, and find out what is available.

Once you have begun the search for information from and about local resources, you will find yourself with an abundance of books, periodicals, pamphlets, and contacts. The next step is to organize the material.

ORGANIZING MATERIALS

There are many ways of organizing print information, but they all rely on a cataloging and classification system. The Dewey Decimal System is a cataloging and classification system. But Dewey would not be appropriate to a collection that is primarily disability related because the headings are too broad to be effectively utilized in a special collection of such narrow focus. This was one of the considerations that led to the development of the *NARIC Thesaurus of Descriptors*. These terms reflect what is going on in rehabilitation and in the research that we receive for inclusion in REHABDATA, a service provided by NARIC. It is a computerized bibliographic listing of over 12,000 citations of rehabilitation literature and documents that is both disability-and format-sensitive. This type of controlled vocabulary has the additional benefit of containing definitions and cross-references to related terms. This structure allows for different people to assign indexing terms, subject headings if you will, with some degree of consistency. Based on NARIC experience with this type classification system, I would heartily recommend it to an ILP attempting to organize materials for a resource center.

If you already have material that needs to be organized, you can develop your own list of subject headings based on that material. Simply arrange that material in piles by their subjects and there is your subject heading list. As you acquire relevant material that does not fit into any of the terms you already have, you add new subject headings.

You should have both subject and title access to your books. If you are going to use a manual system like a library card catalog, this will mean the preparation of at least two cards for each book. A basic library catalog card format is recommended (title, author, and publishing data). The subject card will be an identical card but with the appropriate heading at the top of the card. The subject file can be separate from the title file, but both should be in alphabetical order. If you maintain subject access via a card file, the need for a special area for each subject on specific shelves will be unnecessary. As each item is added to the collection, it is assigned a number, in sequence, and placed on the shelf in that numerical sequence. That number should be added to all cards that are being maintained on that document.

With non-book material, such as pamphlets or manufacturers brochures, you have another decision to make. Files may be set

up using the same subject heading list employed for the books or you may group the material according to the source, i.e., the organization or manufacturer from which they came. It is not likely that filing by source would be functional because in order to retrieve a piece of information, you would have to know the specific source of that information and that would be an unrealistic expectation to have of your patrons. However, subject files and a resource card file of organizations and manufacturer names would give you the same kind of primary source access without sacrificing subject access in the files.

With the material that is acquired for your resource center there are two things, in addition to any assigned call numbers, that must be placed on each piece: the name of the resource center and the date received.

In the long run, acquisition of the material at the beginning of development is not enough. The accuracy and timeliness of the collection must be maintained. The value of the information you collect is only as good as its documented accuracy. Names, addresses, and telephone numbers of the listings in your resource file change without warning. The users of your center should be confident about the accuracy of the information they receive. Maintaining this confidence will require at least as much effort as the initial acquisition of the materials. For both organizations (on a national level) and for manufacturers, NARIC must spend a substantial amount of time in maintaining the integrity of the information we disseminate. No less will be expected of an ILP that is focusing on local resources.

EXPANDING RESOURCES

It is wholly appropriate for the beginning of this resource center to be on a controlled, modest level. But as control and experience are gained, a certain amount of expansion should be expected and planned for. In contacting local chapters of national organizations, you may get some sense of the headquarters operations. But now you may have a need to link up with the national office itself. For example, some of the national organizations maintain their own libraries which can be of immeasurable use in acquiring materials. As you expand, you should investigate those organizations that may not have local chapters, but they may be helpful to your patrons. When you hear or read of other potentially useful resources, be prepared to investigate them in terms of meeting the needs of the resource center.

When the time for expansion comes at the governmental resource level, seek out state government agencies such as the state library or the Governor's Committe on Employment of the Handicapped, to ascertain what they can provide to help your patrons become maximally independent. At the same time, you should look into the abundant resources of federally-funded clearinghouses and federal agencies directly related to disability concerns and/or funding research in disability related areas.

With expansion, investigate the resources available in health sciences libraries (e.g. hospitals, medical schools, or the National Library of Medicine regional libraries) or special libraries (e.g. NARIC or American College of Cardiology). Find out who can use that particular library, what kind of information they have, and how accessible the material and the location are.

One other area of expansion that cannot be ignored is computer technology. You may not want or be able to have your own computer in your resource center, but inform yourself about how computer technology influences the transfer of information relative to disability issues. Much bibliographic research information is available through online databases such as ERIC and MEDLARS. The development of online networks such as Deafnet and SpecialNet have had a tremendous impact on the speed with which information can be transferred. The minimum involvement of an ILP resource center with computer technology should be to know what systems, programs, and/or databases have relevance to that ILP and its patrons and how, either formally or informally, that technology can be accessed.

SUMMARY

The delivery of rehabilitation services to any given population can be greatly enhanced by a free flow of appropriate information. I have focused on how this flow of information could be facilitated at the level of the ILP. But, the principles remain the same regardless of the nature of the group—nonwhite or white, large or small, a formal

program or a group of individuals seeking to get the most out of their environment as they define it.

1. Define the program you want to develop. Set up some attainable goals and some reasonable limits.
2. Collect the information from the most readily available sources with one of the most readily available tools—*the telephone.*
3. Organize that which is collected in a manner that those for whom it was collected can profit from it.
4. Expand the range and depth of your information as time and need dictate.

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22 • Utilizing an Information and Referral Agency in a Changing Society

YETTA W. GALIBER

Information Center for Handicapped Individuals, Inc.

Abstract

This article provides insight into the service and impact of the Information Center for Handicapped Individuals (ICHI). ICHI established in 1969, links handicapped individuals with available services and resources. The Center places special emphasis on the needs of underserved population groups including the poor, blacks, and other minority groups. ICHI decreases the social isolation of handicapped individuals by bringing about systematic change through action-based programming. Such action-oriented programs include information and referral services, the implementation of a protection and advocacy system for developmentally disabled individuals, ancillary services (volunteer projects), case management services for the homebound clients, and a mini-media learning center for vocational rehabilitation clients. The Center also publishes and distributes consumer resource booklets. ICHI success-

fully influences society's view toward understanding and accepting disabled individuals. Details of the Center's programs are discussed.

The term "Information is Power" may be viewed as the philosophical cornerstone of the Information Center for Handicapped Individuals, Inc. (ICHI) in Washington, D.C. The Center, formerly known as the Information Center for Handicapped Children, has been in existence since 1969. The essential mission of ICHI is to link handicapped individuals with available resources and services. Where gaps exist in the service delivery system, ICHI engages in public advocacy to bring about systemic change. For example, ICHI's support and involvement helped the Waddy Decree. This litigation revolutionized educational opportunities for handicapped children in the District of Columbia by making available previously inaccessible educational programs and by mandating the creation of new school programs where warranted.

ICHI has evolved over its 15-year existence as an agency responding to the needs of disabled persons with special emphasis on the needs of the poor, blacks, and other minority groups. ICHI recognizes that advocacy and outreach are essential to ensure services to all persons with disabilities. Thus it has been in the forefront of the effort to: (a) identify the comprehensive needs of handicapped citizens, (b) stimulate the development of new and innovative services, and (c) effect philosophical and policy changes which will result in the creation of programs, and normalize the day-to-day experiences of persons with handicapping conditions.

The ICHI Model which serves as a linkage between the disabled client, his/her family, and service providers helps to decrease social isolation and assists in integrating multihandicapped persons into the mainstream of the community. ICHI's program scope relates to the objectives listed below:

- To provide handicapped clients, consumers, and their parents, representatives, or surrogates with timely and effective information in relationship to expressed needs.
- To provide handicapped clients, consumers, and their parents, representatives, or surrogates with referral counseling allowing them access to appropriate services at points of expressed needs.
- To provide handicapped clients, consumers, and their parents, representatives, or surrogates with follow along and follow-up services to assure that identified resources meet expressed consumer needs in a timely, effective way.
- To equip handicapped clients, consumers, and their parents, representatives, or surrogates to more effectively understand and utilize the service delivery system whenever possible.
- To provide case planning and guidance counseling for handicapped consumers with various needs, who are without the opportunity to receive such services from generic agencies.
- To develop and implement programs of public education and awareness for the general citizenry which will lead to increased sensitivity to the needs of handicapped citizens.
- To effect systemic and institutional reform on behalf of handicapped citizens through a vigorous program of public advocacy emphasizing techniques of catalytic change agentry.
- To provide handicapped citizens with advocacy services particularly through sensitization of the criminal justice system.

ICHI has established a successful track record in initiating action-base programs. What has enabled the concept of the ICHI Model to expand into a multi-faceted information center? The answer lies in the eight programs operating under ICHI's banner:

- Information and Referral Services
- Protection and Advocacy System
- Patient Advocacy Project (PAP)
- Volunteer Advocacy Project (VAP)
- Case Management Services for Homebound Clients
- Client Assistance Project (CAP)
- Developmental Disabilities Offender Advocacy Project (DDOAP)
- Volunteer Projects

The *Information and Referral* component of ICHI maintains a contemporary and exhaustive resource file of services available in the Washington metropolitan area. Specific assistance, counseling, direct intervention, and individual advocacy is pro-

vided in order to link consumers to appropriate services.

The Information Center has designed a media learning center of audiovisual programs in order to assist in the establishment of a more productive and successful rehabilitation program for vocational rehabilitation clients. By utilizing the resources of this facility, the audiovisual programs have a significant impact on the total service delivery system. The audiovisual programs are a definite support system for the vocational rehabilitation clients, vocational rehabilitation administration personnel, and other agencies.

The ICHI also acts as the *Protection and Advocacy System* for developmentally disabled individuals in the District of Columbia. The System assists disabled individuals in obtaining appropriate services and ensures their rights under the provisions of P.L. 94-103 Legislation such as the Developmentally Disabled Assistance and Bill of Rights Act of 1975 as amended by the Rehabilitation Comprehensive Services and Developmental Disabilities Amendments, P.L. 95-602 mandate the provision of service under this service subcomponent.

The *Patient Advocacy Project* (PAP) of ICHI is designed to address the needs of the mentally disabled population served by the District's Mental Health Services Administration (MHSA) and to satisfy the requirements of the *Dixon* class action lawsuit which established patients' right to treatment in least restrictive community settings. PAP is a cooperative, yet independent effort, pointed toward conflict resolution.

The *Volunteer Advocacy Project* (VAP) is designed to further augment and enhance ICHI's services and responsibilities to mentally disabled persons into full community life. The Volunteer Advocates are, in a sense, "gatekeepers" to the community. They function as key persons who can assist in reducing feelings of isolation, helplessness, and estrangement and ensure that the wheels of justice remain well-oiled and moving for mentally disabled individuals.

The Information Center recruits, trains, and supports a network of volunteer advocates to aid mentally disabled persons in their reintegration process.

The *Case Management for Home-Bound Developmentally Disabled Persons Project* of ICHI addresses the problems of service delivery management for home-bound individuals in the District of Columbia with severe and chronic developmental disabilities. This program is designed to improve the efficiency and effectiveness of resource utilization by implementation of a system which assesses client needs and locates and matches available services with client needs. This program also provides coordination of support services for the homebound client.

The ICHI's *Client Assistance Project* (CAP) is established to a) inform current vocational rehabilitation clients and prospective clients of their rights, b) investigate and negotiate solutions to individual problems concerning the delivery of services, and c) assist clients and vocational rehabilitation counselors in overcoming obstacles which interfere with the objectives of the CAP program.

The *Developmental Disabilities Offender Advocacy Project* (DDOAP) is designed to reduce the number of developmentally disabled juveniles committed to incarceration by providing for alternative non-institutional community-based programs. Specifically, DDOAP's purpose is to increase the number of juvenile offenders diverted from adjudication and from incarceration to more appropriate and normalized community settings. However, where this is not possible, to screen and identify offender needs and to increase treatment and educational services provided to these offenders within correctional facilities.

The comprehensive nature of ICHI outreach on behalf of handicapped individuals is exemplified by the array of other ancillary services made available in support of the full integration of the disabled into community life. These services, while not a part of the above project components, are additional volunteer projects and activities. They include the following:

Annual Christmas Store—ICHI conducts an annual Christmas Store for needy handicapped children. Ten dollars in play money is given to each child. The store provides a shopping experience for toys and other items donated by the community. The efforts demonstrated by ICHI help to create a feeling of joy and happiness for needy children and their families during the Christmas season.

Miss Wheelchair D. C. Pageant. The purpose of this annual pageant is to demonstrate the dignity, productivity, and basic value of handicapped persons. The winner represents the District of Columbia in the Miss Wheelchair America Pageant held every year in Columbus, Ohio.

These direct efforts reduce disability dependence and promote self-sufficiency and access to the marketplace for disabled persons (Knauer, 1984).

Recognizing that information is of little benefit if it is not disseminated and utilized, ICHI has published and distributed thousands of copies of consumer resource booklets. These publications are widely utilized in the Washington metropolitan area by universities, hospitals, local and national government agencies, schools, parent organizations, and other interested persons. These publications are:

Directory of Services for Handicapping Conditions. Designed to enhance and facilitate the accessibility of services on behalf of consumers, the directory dynamically demonstrates the role assumed by ICHI as people are linked with existing services.

Directory of summer programs: "Here comes the sun." This publication focuses on available summer activities and programs for handicapped children. ICHI plays an active role in disseminating this publication in order to lessen the effects of social and recreational inactivity during the summer months.

Directory of social services for Spanish speaking community. ICHI developed this publication for the Spanish-speaking community in order to link Hispanics with available resources and provide information on legal rights and effective individual advocacy.

Access Washington, A guide to Metropolitan Washington for the physically disabled. This publication is significant to the implementation of Section 504 of the Vocational Rehabilitation Act of 1973 as it relates to architectural barriers. On-site surveys were conducted by handicapped and non-handicapped individuals in order to evaluate accessibility. Graphics and illustrations accompany narrative and statistical data which create a valuable document for physically disabled individuals.

ICHI Newsletter. This publication is disseminated to all service organizations and agencies in the community in order to update their knowledge of special events, new programs, and services available in the Washington metropolitan area.

The ICHI service model is based upon an action plan which guides the flow of information. This action plan is built upon the "theory Z" principles of trust, understanding, intimacy, communication, outreach, networking, collaboration, and teamwork. (Vogenthaler, 1985). The model may be expressed in terms of a formula: knowledge + action = access.

ICHI's experience has shown that fundamental attitudinal changes occur through enlightenment, effective information, and eradication of the ignorance that engenders prejudices and discrimination toward persons with disabilities. This strategy of acting as a liaison between resources and persons with disabilities has been effective. Thus, ICHI is a uniquely powerful influence assessing the capacity of communication and utilizing it to shape society's view towards understanding, accepting, and affording meaningful opportunities to all disabled persons (Rehabilitation International, 1982) especially the poor, blacks, and other minorities.

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23 • Using Traditional and Confrontational Politics to Influence Established Trends

DON ABASI GALLOWAY
D. C. Services for Independent Living, Inc.

Abstract

This article highlights action oriented techniques for the disabled in their efforts to resolve some of the current concerns and problems associated with the contemporary issue of political power. Locality development, social planning, and social action are three traditional approaches recommended by the author to achieve resolutions. The disabled community is urged to utilize these and other effective strategies in their efforts to ameliorate attitudinal and physical barriers which inhibit them from accessing political power. Once strategies for confrontational and traditional politics become formalized competency for disabled groups, they will be able to negotiate and serve the disabled community more readily and effectively.

There are numerous political and legal considerations associated with the issue of political power and nonwhite persons with disabilities. In discussing the issue of organizing disabled people to influence policymakers and legislation, it is important to recognize that nonwhite and severely disabled people are traditionally a disenfranchised population. The characteristics of an oppressed people are the same be they black, women, or disabled citizens. They experience a pervasive hopelessness and powerlessness. It is crucial to instill within this population a sense of being able to accomplish one's goal. In analyzing the problem, it is felt that every legal means should be used to enlighten and motivate people to facilitate action oriented goals resulting in some real tangible changes.

The three traditional approaches used by social workers and other professionals are:

1. Locality Development—presupposes that community change may be pursued optimally through broad participation of a wide spectrum of people at the local community level in goal determination and action.
2. Social planning—emphasizes a technical process of problem-solving with regard to substantive social problems, (e.g. delinquency, housing, and mental health).
3. Social Action—presupposes a disadvantaged segment of the population that needs to be organized, perhaps in alliance with others, in order to make ade-

quate demands on the larger community for increased resources or treatment more in accordance with social justice or democracy.

In studying these three approaches, it becomes quite obvious that no single approach can work if there is going to be a successful change of policy to influence current trends.

The following are seven steps to the empowerment process.

1. Recognizing that a problem that any one individual has is also experienced by other individuals.
2. Coming together with others to discuss the scope of the problem.
3. Determining the most important issue that faces the group.
4. Planning a strategy of action.
5. Taking action.
6. Evaluating the response to the action.
7. Planning for the next activity, based on the results of the assessment.

In the process of social change, there will be successes and failures. It is most important to instill in the change agent group a desire to persevere and the stamina to endure. Persistence and endurance will convince bureaucrats of the group's commitment and willingness to take risks. While these criteria may manifest themselves in aggression or assertion, conflict surely precipitates change. Obtaining one's goal is a continuous process. Once the goal has been achieved, new objectives and goals must be set.

Power to control and direct public policies can be one of the goals. Power can be found through people, information, knowledge, creativity, and money. Since most small groups dedicated to social change have little or no money, it is important that they develop and utilize these three resources.

1. *People*—It is popularly believed that large numbers of people are needed to bring about change. In some cases this is true. For example, if there is a politician who is up for election, having people power is important. It is also helpful to have a large number of people when there is a public protest plan. However, the core group should remain small and the leadership should be clearly identified. The core group should speak for the larger group with the clear consensus and acceptance by the larger group. The group members must have a basic understanding of the issue and the solution to the problem if the core is to be successful in including the members in any action plan. On the other hand, large groups can be cumbersome and ineffective if they are not well organized.
2. *Information*—The group should approach the problem as if their lives depended on it. An in-depth analysis should be done on every aspect of the problem. A library should index each facet. Dossiers should be gathered on all principal bureaucrats who can effect a positive change. The likes and dislikes of each of these persons can be important. Knowing the politics of key decision makers can be crucial. The information should be collected and shared with study groups. Information collection should be an on-going process. The bureaucracy should also be studied with care. The line of authority each bureaucrat has within the structure should be analyzed. It is important to determine the formal and informal powerbrokers; in short, those who can make decisions. Each department of government operates under written legislation and policy. The law and policy should be thoroughly understood. The core group should understand the operating procedures under which the adminstrators function.
3. *Knowledge*—Knowledge is gathered from the analysis of all of the information collected. Some in the group will be more knowledgeable than others but it is important to ensure maximum input from the entire body. This allows for creativity and new insights. Authorities will respect your knowledge base and will come to negotiate with a sense of equality. Once this equality is evident, there will be a closer collaboration for resolution of the problem.

If the authorities refuse to respond in a positive way, the tactics should be changed to confrontational politics. Organized groups should be mobilized and a review of the prior process should occur. A new action plan should be presented and the members of the group must accept the new stratagem. After concurrence, the target should be identified, and a press release sent to the

appropriate media. The adversary should then be confronted.

The following will be some of the basic principles of confrontation:

1. It is important to have a clear statement of goals.
2. Do not try to understand the rationale of the adversary as there is a danger of members being co-opted.
3. Ask for more than what you think is possible to obtain. Leave some space for the adversary to negotiate.
4. Maintain pressure at all levels.
5. Take the confrontation to the adversary's environment.
6. Keep the press supportive of the group's issues.
7. Form coalitions with other groups that identify with the issue.
8. Do not allow the adversary to divide the group. Make sure they speak to the appointed leadership.

These are just a few of the tactics needed to bring the issue back to the table. Make sure that group support is maintained at every phase of action. Once the adversary sees that the issue is supported by the general public, the negotiators will have a greater opportunity to come to an agreeable position.

Once there is an agreement, it is important to make alliances with the adversary. They should be congratulated on their support of the issue and an environment that is conducive to future collaboration should be established. Confrontation politics, when correctly implemented, serves as an invaluable tool for demystifying the political aura that surrounds the inalienable rights of the disabled community (Tesolowski, Rosenberg, Stein, 1983).

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24 • Observations of a Neophyte Lawyer "Four Observations—Three Proposed Solutions"

PAMELA J. YOUNG
District of Columbia
Superior Court

Abstract

The author, a lawyer who having recently entered the area of mental retardation advocacy, makes several observations. First, the need for a local Mental Retardation Legal Advocacy Bar to educate attorneys and network resources for maximum effectiveness is discussed. Second, the compensation of volunteers in order to decrease the lag in service delivery is proposed. Third, the development of administrative advocacy techniques to eliminate the legal tactics designed to delay proceedings is discussed. Fourth, the author notes that burnout is high among legal and lay advocates in this area. Finally, the author suggests that consolidation of lay and legal advocacy may become necessary in order to maximize resources.

Law school rarely prepares attorneys for a practice that is primarily oriented toward social welfare issues. My own educational background left me devoid of training that would give me flexibility and adaptibility necessary to become a public interest lawyer. Although I have practiced for ten years, I am a neophyte in the field of mental retardation advocacy. Presently I hold the position of Hearing Commissioner in the Family Division of the District of Columbia Superior Court. My responsibilities include the tasks of reviewing mental retardation commitments, transfers, judicial placements and discharges, and other duties as assigned.

In the District of Columbia there are two classes of advocacy. Both are codified in §6-1901 *et seq* of the District of Columbia Code 1981 edition as amended. First, there are attorneys appointed pursuant to §6-1942. These individuals must comply with the statutory mandate that:

> Respondents shall be represented by counsel in any proceeding before the Court, and shall be so informed.

The second class of advocacy is a trained lay person with specific statutory duties and responsibilities established pursuant to §6-1953. These individuals are given "access to all records and documents affecting the client." The attorneys who comprise the legal advocates are typically private practitioners who are given training by the Hearing Commissioners on the statutory and case authorities. There are few attorneys who specialize in mental retardation advocacy. The lay mental retardation advocates are recruited through television ads and from schools, churches, and other volunteer groups. The varying backgrounds and responsibilities of the two classes of advocates compel me to share four observations with accompanying solutions.

> *OBSERVATION ONE.* The attorneys have not organized to form a mental retardation section, sub-group, or division of the Domestic Relations Section or Family Law Section of the District of Columbia Bar.

Most attorneys recognize the individual problems of his or her given clients, but as a Commissioner with the responsibility of hearing numerous cases on an ongoing basis, I have begun to identify many systemic problems which easily could be resolved through the establishment of a local Mental Retardation Legal Advocacy Bar designed to educate attorneys, catalog memorandum and decisions by various Judges and Hearing Commissioners, networking of resources, and maximizing their effectiveness.

OBSERVATION TWO. The most important person in the statutory framework for enforcement of the statute is the Mental Retardation Advocate. This individual is not compensated.

The crux of the "Mental Retardated Citizens Constitutional Rights and Dignity Act of 1978" is the creation of a body of individuals that will "step into the shoes of the mentally retarded individual," and provide him with the ability to safeguard that individual's rights. This individual goes through extensive seven-week training to qualify as a knowledgeable advocate. More than 1,000 individuals have been committed by the District of Columbia court; almost 400 active advocates would be needed to effectively carry out the statutory plan. Massive recruitment efforts were initially successful and advocates were a cohesive body that carried out "their appointed tasks." However, as volunteers realized the enormous responsibility they had assumed—the time commitments involved in visiting clients, group homes, day placements, and attending hearings, and the longevity of their commitments—many dropped out of the program and recruitment began to lag. To effectively achieve the statutory mandate of advocates there must be some compensation for the services provided.

OBSERVATION THREE. Legal advocacy by both the lay and attorney advocates can never overcome or offset administrative red tape or judicial calendaring problems.

The nature of any bureaucracy leads one to the conclusion that the simpler the problem the tougher the solution. The attempt to resolve administrative problems through judicial solutions often result in further delay caused by judicial calendaring problems or by legal tactics designed to delay. The lawyer uses many tools in his work and most of them (e.g. emotions, discovery, oppositions) are designed to wear an opponent down. Advocates (lay and legal) should develop sound administrative advocacy techniques designed to get results. A positive approach to this form of advocacy could lead to a solution that may not be everything that you want but, most assuredly, could result in a quicker solution to the problem.

OBSERVATION FOUR. Burnout is high.

There are three types of burnout prevalent among legal and lay advocates. The most obvious category includes those who are "overburdened." These individuals tend to be involved in a number of emotionally draining areas (e.g. juvenile cases, neglect, domestic violence, child abuse, and divorce and custody problems). The second type includes the advocate who has become "confrontational." This person has polarized a few key individuals in the system and the only effective advocacy is confrontational. The third category includes those individuals with "tunnel vision." Usually, these individuals were involved in the establishment of statutory rights for the mentally retarded. They continue to fight *against the system* without exhibiting flexibility or accepting new ideas.

In conclusion, my last observation, which I have not numbered, is a hypothetical suggestion:

IT WOULD BE MORE EFFICIENT AND MORE EFFECTIVE TO CONSOLIDATE THE LAY AND THE LEGAL ADVOCATE TO MAXIMIZE RESOURCES. EACH COULD FULFILL A ROLE BASED ON HIS/HER COMPETENCY LEVELS.

The observations which have been shared are personal and must include my legal disclaimer: They do not reflect the policy of the District of Columbia Superior Court, my employer.

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